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**Traditional Chinese Medicine & Acupuncture**  
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Twelfth Avenue Acupuncture and Herb Clinic

*Personal and Confidential*

*Please read the following carefully.*

Thank you for your interest in Traditional Chinese Medicine, TCM & TCM Acupuncture. TCM & TCM Acupuncture can be used for treatment and prevention.

All patients are urged to consult their own family physician, or specialists regarding current or future conditions. TCM & TCM Acupuncture is meant to be used as a complementary treatment.

Your treatment may be covered under your health insurance plan or with SGI.

Please ask if you have any questions.

I have read and understand the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Data  
Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_

Work: (W) \_\_\_\_\_ Cell: (C) \_\_\_\_\_ Fax: \_\_\_\_\_

How did you hear about my office:  friend  phone book  sign other \_\_\_\_\_ Occupation: (your) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Daytime # \_\_\_\_\_ Other # \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you experienced the Chief Complaints \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How have they progressed \_\_\_\_\_

Physician's Diagnosis \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Bowel Movements**

How many bowel movements do you have per day \_\_\_\_\_ Are they well formed/dry/loose/many small ones/other \_\_\_\_\_  
 Do you have a tendency to constipation or diarrhea \_\_\_\_\_

**Urination**

How many times is water passed per day \_\_\_\_\_ Most of the time is the color clear/light yellow/dark yellow/other \_\_\_\_\_  
 Do you have to wake up in the middle of the night to pass water always/often/sometimes/very rarely/never \_\_\_\_\_

**Digestion, Appetite, Diet**

How do you feel your digestion is excellent/good /poor/other \_\_\_\_\_  
 Why \_\_\_\_\_

Describe what your diet is like \_\_\_\_\_

How is your appetite \_\_\_\_\_

Do you have any cravings (sweet, salty, etc) \_\_\_\_\_

Do you have heartburn/cramping/bloating \_\_\_\_\_

**Thirst**

What beverage temperature you prefer to drink cold/room temperature/hot \_\_\_\_\_

**Body Temp**

Are you one to turn up the heat in a room or turn it down? \_\_\_\_\_

**Sweating**

Do you sweat on exertion spontaneously at night other \_\_\_\_\_

**Pain**

**1** Area \_\_\_\_\_ Pain Numbness Burning Tingling/Pins and Needles Other \_\_\_\_\_  
**2** Area \_\_\_\_\_ Pain Numbness Burning Tingling/Pins and Needles Other \_\_\_\_\_  
**3** Area \_\_\_\_\_ Pain Numbness Burning Tingling/Pins and Needles Other \_\_\_\_\_  
**4** Area \_\_\_\_\_ Pain Numbness Burning Tingling/Pins and Needles Other \_\_\_\_\_

Please Fill in the following chart

Area	Pain Level 0 (Pain Free) –10 (unbearable)	How often is the pain (Example 1/day, constant, 1/week)	When did the pain start	Why do you think it started	What makes it feel worse	What makes it feel better	Is the pain dull or sharp	Is it worse at different times of the day	Do you take any painkillers or anti-inflammatories for the pain  If so, what and how many	Has it been getting worse or better since it started
1										
2										
3										
4										

Is the pain relieved by heat cold neither unsure other \_\_\_\_\_

Is the pain worse with different kinds of weather hot cold damp unsure other \_\_\_\_\_

Emotions

**None** = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning • **Moderate** = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe
Sad				
Irritability				
Over thinking				
Fear				
Nervous				

Sleep and Energy Level

On Average, how many hours do you sleep per night? \_\_\_\_\_

Do you wake up in the middle of the night? If so how often \_\_\_\_\_

Do you have  a lot of vivid dreams  a few dreams  not many at all

How is your energy level \_\_\_\_\_

Lifestyle

Do you  smoke how much \_\_\_\_\_  drink alcohol how much \_\_\_\_\_

caffeine how much \_\_\_\_\_  exercise how much \_\_\_\_\_

Work \_\_\_\_\_ hrs/week

Surgeries/Procedures

List surgeries

YEAR _____	YEAR _____
YEAR _____	YEAR _____

Illnesses

List physician diagnosed illnesses

YEAR _____	YEAR _____
YEAR _____	YEAR _____

Family Health History

Mother \_\_\_\_\_

Father \_\_\_\_\_

Other \_\_\_\_\_

Women

How many days do you bleed for \_\_\_\_\_

What color is the blood \_\_\_\_\_

Any pain with your period \_\_\_\_\_

Is it  before  during  after your period

Does pressing the area make the pain feel  better  worse  no effect

Do you get PMS? \_\_\_\_\_

What is it like? \_\_\_\_\_

Have you ever had a miscarriage or D&C \_\_\_\_\_

How old were you when you had your first period \_\_\_\_\_

How old were you at menopause \_\_\_\_\_

What is it like? \_\_\_\_\_

How heavy is your flow \_\_\_\_\_

How long is your cycle \_\_\_\_\_

Is the pain alleviated  hot  cold

How many children do you have \_\_\_\_\_