Martina Vengrin
ACUPUNCTURE & NATUROPATHY

New Patient Form

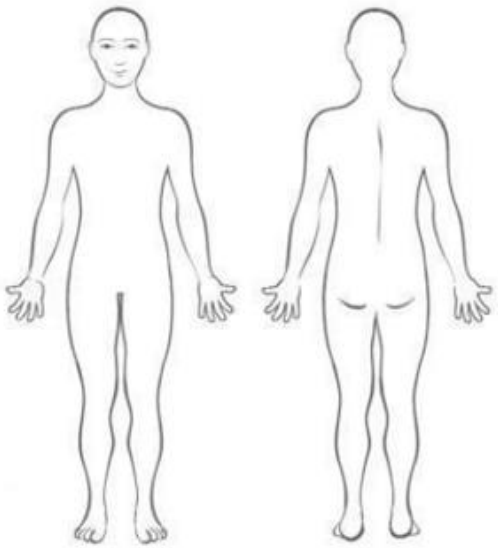
Name…… **Date of Birth**……
Address…… **Email**……
Occupation…… **No. of children/ age**……
GP…… **Emergency contact**……

Is this your first acupuncture treatment? Yes/ No
Other medical treatment received: physio/chiro/osteo/others

GP/Consultant's diagnosis……
……

Please mark the areas of concern/pain:

Circle discomfort/pain level: 1-10 (None…unbearable)



Conditions relieved by (activity, rest, ice, heat…)
Conditions aggravated by (weather, heat, cold…)
Current prescribed medication
……
……
……
Current supplements, herbs……
……
……
……

List of allergies (food, drugs, environment, etc.)
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……

Any surgery, past or awaiting
……
……

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Family Medical History: Please indicate with a **P (past), C (current), or F (family)** if any of the conditions below apply:

Low Blood Pressure		Epilepsy		Jaundice		Arthritis	
High Blood Pressure		Dizziness/Fainting		Jaw pain		Cancer	
Heart condition		Lung condition		Hepatitis		Endometriosis	
Thrombosis/Embolism		Skin condition		Headache/Migraine		Uro/Gynae	
Pacemaker		Osteoporosis		Cataracts/Macular degeneration		Digestive issues	
Stroke		Diabetes		Kidney condition		Others	

Patient Medical History: Please indicate severity of current symptoms, rated 1-10 (10 being the worst). Leave blank if n/a.

ST/SP		Yeast infection		Painful urination		Brittle nails	
Constipation (C)		Always cold		Wake to urinate		Signing	
Loose stool (LS)		Prefer warm food		Bring water to bed		PMS	
Both (C &LS)		Prefer warm drink		Low sex drive		Genital itching/pain/rashes	
Nausea/vomiting		Cold feet, warm hands		High sex drive		Headaches/Migraines	
Bloating/gas		Cold feet, cold hands		Kidney stones		Emotional eating	
Intestinal pain/cramping		Snoring		Dark urine		Irritable/frustrated/impatient	
Stool marks toilet bowl		Tiredness/fatigue		Smelly urine		Gallstones	
Abdominal pain		LU/LI		Loss of hair on head		Nightmares	
Heartburn		Sinus/congestion		Hearing problems		Clenching teeth	
Indigestion		Cough with Phlegm		Tinnitus			
Belching/burping		Dry cough		Fear		HT/SI	
Heaviness in head/body		Nasal drip		Bad long-term memory		Chest pain/tightness	
Brain fog		Dry mouth/nose		Swollen ankles		Disturb sleep/insomnia	
Tired after eating		Sore throat		Crave salty foods		Difficulty going to sleep	
Difficult getting up a.m		Skin rashes		Night sweats/hot flash		Mid racing	
Tired weak muscles		Asthma/wheezing		Lower back/knee pain		Palpitations	
Bruise easily		Cough up blood		Very thirsty		Vivid dreams	
Bad breath		Catch cold easily		No thirst		Mouth/tongue/lip ulcers	
Bleeding gums		Hay fever		Osteoporosis/penia		Forgetfulness	
Haemorrhoids		Weak immune system		LV/GB		Lack of joy in life	
Nose bleeds		Alternate chills/fever		Depression		Bitter taste in mouth	
Blood in stool		Grief/sadness		Stress		High blood pressure	
Hours without food		Shortness of breath		Floaters in eyes		Irregular heartbeat	
Large appetite		Sweating during day		Itchy/dry eyes		Restless/agitated	
Water retention		KD/BL		Dizziness		Anxiety	
Overweight		Frequent urination		Feeling like lump in throat		Tingling in fingers	
Overthinking		Leaking urine		Discomfort at sides under ribs		Tingling in toes	
Worry		Urgency to urinate		Neck/Shoulder tension			
Sweating on forehead		Bladder infections		Muscle twitch			