The Healthworks Clinic

www.thehealthworksclinic.com E: info@thehealthworksclinic.com

CONFIDENTIAL

The Healthworks Clinic Acupuncture & Health Questionnaire
Please be honest as you can, all the information is strictly confidential

DATE:

GENERAL INFORMATION

Name: ____

Address: ____

____

Email: ____

CONTACT NUMBERS

Home. : ________________ Work:________________ Mob: ________________

Date of Birth : ________________

Age : ________________

Weight: ________________ Height: ________________

Blood Group (If Known): ________________

Status/Present Occupation : ________________

Female: Male:

Marital Status: ________________

Pregnancies:________________ Miscarriages:________________

Children: ________________ Ages: ________________

GP Name: ________________ Phone: ________________

Address: ____

MEDICAL HISTORY

Medical Conditions: (e.g. Pacemaker) : ________________

Smoker: (amount per day) ________________

Surgery: ________________

Major trauma or accidents: ________________

Medication: (Please list all medication, daily dosage and period of treatment)

Antibiotics : __________ Pain killers __________ Steroids__________ Laxatives__________

Blood thinners : __________ Indigestion Tablets: __________Anti-inflammatories__________ HRT__________

Antidepressants: __________ Contraceptives: __________Sleepings tablets: __________ Others__________

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NATURAL MEDICATION OR TREATMENTS

Homeopathy: ______________________ Supplements: ______________________

Acupuncture: ______________________ Herbs: ______________________

Vitamins: ______________________ Massage/Reflexology: ______________________

Osteopathy: ______________________ Chiropractor: ______________________

Physiotherapy: ______________________

Main Problem requiring treatment: ______________________ Duration: ______________

Worse for: ______________________ Better for: ______________________

Symptoms: ____

Hospital Stay Overs:____

FAMILY MEDICAL HISTORY

(Include any hereditary illnesses e.g. addiction, cancer, diabetes, heart problems, etc.)

Grandparents:______________________ Parents:______________________

Aunts + Uncles:______________________ Siblings:______________________

Brothers / Sisters______________________ Children:______________________

AVERAGE DAILY DIET

Breakfast:______________________ Lunch:______________________

Dinner:______________________ Snacks:______________________

Drinks:	Tea / Coffee:	Soft Drinks:	Alcohol:	Water:
	________	________	______	________
	________	________	______	________
	________	________	______	________

Exercise:	Regular ☐	Irregular ☐	None ☐	Amount per/wk ____________
Bowel Movements	Daily ☐	Every 2 Days ☐	Every 3-5 Days ☐	More ☐
Meditation:	Personal ☐	Group ☐	Mass ☐	None ☐

Is there anything else you feel may be relevant? (accidents, traumatic experiences, etc.)

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The following is a list of symptoms that you may or may not experience:

Mark		Meaning
No Mark	=	Never Experience
>	=	Sometimes Experience
+	=	Frequently Experince

CARDIOVASCULAR		**GASTROINTESTINAL**		**MALES ONLY**	
Shortness of breath		Indigestion		Prostate Problems	
High Blood Pressure		Abdominal Cramps / Pain		Pain In Testicles	
Irregular Heart Beat		Constipation			
Dizziness		Diarrhoea		**FEMALES ONLY**	
Chest Pain or Pressure		Blood Bowel Movement		Pre Menstrual Pain	
Leg Cramps		Black Bowel Movement		Pain with Period	
		Excess Appetite		Irregular Menstrual Cycle	
RESPIRATORY		Decreased Appetite		Breast Swelling and Pain	
Cough		Excess Thirst			
Cough Up Blood		Nausea or Vomiting		**MISCELLANEOUS**	
Sore Throats		Colitis or Diverticulitis		Jaundice	
Nasal Problems		Heartburn		Hepatitis	
Asthma or Wheezing		Belching or Burping		Memory Loss	
Pneumonia		Gall Stones		Hearing Loss	
Hay Fever				Ringing in Ears	
Bronchitis		**GENITOURINARY**		Headaches	
Catches Colds Easily		Frequent Urination		Sore or Dry Eyes	
		Painful Urination		Insomnia	
SKIN		Vaginal Discharge		Fever	
Ulcerations		Venereal Disease		Chills	
Rash		Pain in Genital Area		Night Sweats	
Oedema		Decrease Sex Drive		Day Sweets	
Acne		Kidney Stones		Intolerance to WeatherChange	

NOTE: 24 Hours notice of cancellation or schedule change is required. Same day cancellation will be charged the full cost of your treatment(s).

Signature of Patient:

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