ALLISON KUCAN HAHN, B.SC.(HONS), R.AC, R.TCMP
Registered Acupuncturist &
Traditional Chinese Medicine Practitioner

KUCAN CHIROPRACTIC & ACUPUNCTURE CLINIC

285-12th Street, Hanover, ON · 519-364-3020 · KucanAcupuncture@gmail.com

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile and Chinese Medicine diagnosis for you. All of your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets. Thank you.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Is it OK to leave a message at home? YES/NO On your cell? YES/NO At work? YES/NO

Referred by: _____ Physician: _____

Emergency Contact: _____ Phone: _____

Have you ever had acupuncture before? YES/NO

Have you ever taken Chinese herbal medicine before? YES/NO

If yes, please tell me what the experience was like.

_____

_____

_____

MAIN COMPLAINT (Symptoms? Diagnosis? When and how did it start?)

What makes your condition BETTER? (Rest, movement, heat, cold, fresh air, crying, weather, etc.)

What makes your condition WORSE? (Stress, fatigue, hunger, position, heat, cold, foods, weather, time of day/month, etc.)

What other interventions have you tried? (Doctors, tests, therapies, medications, supplements, etc?)

YOUR MEDICAL HISTORY:

Significant Accidents or Traumas (physical and/or emotional)

Surgeries (including dates)

Medications (including names & dosages; please attach an additional page if necessary)

Vitamins/Supplements/Herbs (please attach an additional page if necessary)

PERSONAL HEALTH HISTORY (Please check any condition or symptoms that <u>YOU</u> HAVE NOW, OR HAVE EVER HAD IN THE PAST)

- o Addiction
- o AIDS/HIV
- o Anemia
- o Appendicitis
- o Arthritis
- o Asthma
- o Autoimmune disease
- o Birth trauma (your own birth)
- o Bleeding disorder
- o Cancer
- o Chicken pox
- o Chronic fatigue
- o Chronic pain
- o Crohn's/Colitis
- o Diabetes
- o Diverticulitis/IBS
- o Elevated blood cholesterol
- o Epilepsy
- o Food allergies/intolerances
- o Gastritis/pancreatitis
- o Heart disease
- o Hepatitis
- o Herpes
- o High/low blood pressure
- o Hyper-/hypoglycemia
- o Infertility
- o Kidney disease
- o Liver/gallbladder disease
- o Lung disease
- o Lyme disease
- o Measles
- o Multiple sclerosis
- o Mumps
- o Pacemaker
- o Polio
- o Respiratory/environmental allergies
- o Rheumatic fever
- o Scarlet fever
- o Seizure
- o Stroke
- o Thyroid disorder
- o Tuberculosis
- o Ulcers
- o Whooping cough
- o Other _____
  _____
  _____

EXERCISE

Days per week? _____ Types of activities? _____ Length of workout? _____

DIET

Meals per day? _____ Snacks? _____ Caffeine? _____ Alcohol per week? _____

FAMILY MEDICAL HISTORY (Please check any condition THAT APPLIES TO YOUR IMMEDIATE FAMILY. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) in the blank.)

- o Addiction _____
- o Allergies _____
- o Asthma _____
- o Cancer _____
- o Diabetes _____
- o Heart disease _____
- o High blood pressure _____
- o Thyroid disorder _____
- o Seizures _____
- o Stroke _____
- o Other _____
- o _____

Please CHECK if you have had any of the following symptoms IN THE LAST YEAR.
Please CIRCLE if you have had any of the following symptoms IN THE PAST, BUT DON'T ANY LONGER.

GENERAL

- o Poor appetite
- o Insomnia/poor sleep
- o Shift work
- o Fatigue
- o Sudden energy drop
- o Fainting
- o Weakness
- o Heaviness
- o Chills/Cold
- o Feverishness/Heat
- o Night sweats
- o Sweats for no apparent reason
- o Localized sweats/clamminess
- o Tremors/tics
- o Poor balance/frequent falls
- o Cravings
- o Strong Thirst (Hot/Cold drinks)
- o Change in appetite
- o Bleed/bruise easily
- o Weight loss
- o Weight gain

SKIN AND HAIR

- o Rashes
- o Ulcerations
- o Hives/Allergic Dermatitis

SKIN & HAIR CONT.

- Itching
- Dryness
- Eczema/psoriasis
- Dandruff
- Hair Loss
- Recent moles
- Skin discoloration
- Acne
- Change in hair/skin texture
- Face flushing
- Dermatitis
- Warts
- Fungal infection
- Weak/ridged nails

HEAD, EYES, EARS, NOSE AND THROAT

- Eye strain/pain
- Eye redness/itching/dryness
- Poor/blurry vision
- Glasses
- Night blindness
- Color blindness
- Floaters
- Cataracts
- Glaucoma
- Headaches
- Migraines
- Dizziness
- Vertigo
- Ringing in ears
- Earaches
- Poor hearing
- Facial pain/pressure
- Sinus problems
- Environmental allergies
- Post-nasal drip
- Nose bleeds
- Jaw pain/clicks/locks
- Grinding/clenching teeth
- Dental/gum problems
- Dry mouth
- Peculiar tastes/smells
- Sores on lips/tongue
- Recurrent sore throat/colds
- Difficulty swallowing

RESPIRATORY

- Cough/wheezing
- Asthma
- Bronchitis
- Pneumonia
- Pleurisy
- COPD/Emphysema
- Pain with deep inhalation
- Tight sensation in chest
- Coughing up blood
- Exposure to smoke/fumes
- Difficulty inhaling/exhaling
- Difficulty breathing when laying down
- Difficulty breathing with exertion

- Production of phlegm… What color? _____

CARDIOVASCULAR

- Chest pain/pressure
- Irregular heart beat
- Palpitations at rest
- Fainting
- Dizziness
- Cold hands/feet
- Swelling of hands/feet
- Blood clots
- Varicose/Spider veins
- Phlebitis
- Shortness of breath
- High blood pressure
- Low blood pressure

GASTROINTESTINAL

- Poor appetite
- Heavy appetite
- Significant thirst
- Preference for hot/cold drinks
- Bad breath
- GERD/acid reflux
- Indigestion
- Belching
- Nausea
- Vomiting
- Food cravings _____
- Food intolerances _____
- _____
- Hiatal hernia
- Bloating/edema
- Abdominal pain/cramping
- Irritable bowel
- Crohn's/Colitis
- Diarrhea
- Constipation
- # of bowel movements per day? _____
- Loose stools
- Explosive/urgent stools
- Burning stools
- Dry/hard stools
- Gas
- Chronic laxative use
- Black stool
- Blood in stool
- Hemorrhoids
- Rectal pain

GENITO-URINARY

- Frequent urination
- Urgent urination
- Unable to hold urine
- Pain on urination
- Burning on urination
- Blood in urine
- Cloudy urine
- Difficulty forming stream
- Dribbling after urination
- Copious flow
- Scanty flow
- Kidney stones
- Urinary tract infection
- Genital sores
- Herpes
- Excessive libido
- Low libido

- Night urination… What time? _____ How often? _____

FOR MEN ONLY

- o Impotence
- o Premature ejaculation
- o Nocturnal emission
- o Pain in testicles
- o Prostatitis

FOR WOMEN ONLY

- o Difficult/painful intercourse
- o Vaginal dryness
- o Vaginal sores
- o Vaginal discharge
- o Infertility
- o Irregular menstruation
- o Painful menstruation
- o Heavy bleeding
- o Scanty bleeding
- o Clots in menses
- o Bleeding stops and starts
- o Bleeding between periods
- o Ovarian cysts
- o Endometriosis
- o Polycystic Ovarian Syndrome
- o Pelvic Inflammatory Disease
- o Uterine fibroids
- o Painful breasts
- o Fibrocystic breast tissue
- o Menopausal
- o Menopausal symptoms _____
  _____
  _____
  _____
- o PMS symptoms _____
  _____
  _____
  _____

- o Age at first menses _____
- o Date of last menses _____
- o Number of days between periods _____
- o Number of days of bleeding _____
- o Number of pregnancies _____
- o Number of live births _____
- o Number of ectopic pregnancies _____
- o Number of miscarriages _____
- o Number of abortions _____
- o Date of last PAP/Pelvic _____
- o Do you use birth control? YES/NO
- o What type? _____
  For how long? _____

MUSCULOSKELETAL

- o Muscle pain
- o Muscle weakness/fatigue
- o Muscle spasms
- o Muscle stiffness
- o Sprains/strains
- o Tendonitis
- o Bursitis
- o Neck pain
- o Shoulder pain
- o Rotator cuff injury
- o Arm/elbow pain
- o Hand/wrist pain
- o Carpal tunnel syndrome
- o Sciatica
- o Hip pain
- o Knee pain
- o Leg pain
- o Foot/ankle pain

- o Back pain… Upper? _____ Middle? _____ Lower? _____
- o General soreness/weakness in lower body (back, hips, knees, ankles, feet)

NEUROPSYCHOLOGICAL

- o Nerve pain
- o Seizures
- o Loss of balance
- o Vertigo/dizziness
- o Areas of numbness
- o Lack of coordination
- o Poor memory
- o Difficulty concentrating
- o Concussion
- o Depression
- o Nervousness
- o Anxiety/panic attacks
- o Restless/jittery
- o Difficulty sleeping
- o Busy dreaming
- o Bad temper/irritable
- o Easily susceptible to stress
- o Seasonal Affective Disorder
- o ADD/ADHD
- o Bipolar disorder
- o OCD
- o PTSD
- o Other _____

Have you ever been treated for mental health problems? YES/NO
Have you ever considered or attempted suicide? YES/NO
Have you ever been treated for substance abuse? YES/NO

COMMENTS

Please inform me of any other issues you would like to discuss.

_____

_____