Healing Tree
natural medicine

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Patient Information All information will be kept strictly confidential **Date:** _____/_____/_____

Name: _____ Male/Female DOB: _____/_____/_____

Address: _____

Phone (mobile): _____ Email: _____

Height: _____ Weight: _____ Marital Status: _____

Emergency Contact No.: _____ Name: _____ Relationship:_____

How did you hear about us? □ Google □ Professional Referral □ Word of mouth □Other: _____

Name and contact of GP/Specialist: _____

Please describe the specific reason for your visit today and other health concerns: _____

_____

Please indicate if you have/have had any of the following:

- ❑ Sinus problem
- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Skin diseases:_____
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Fatty liver
- ❑ Asthma
- ❑ Epilepsy
- ❑ Heart problems
- ❑ Kidney problems
- ❑ Any surgical implants
- ❑ Cancer history
- ❑ Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any **surgeries/operations, major accidents or injuries**, please explain:

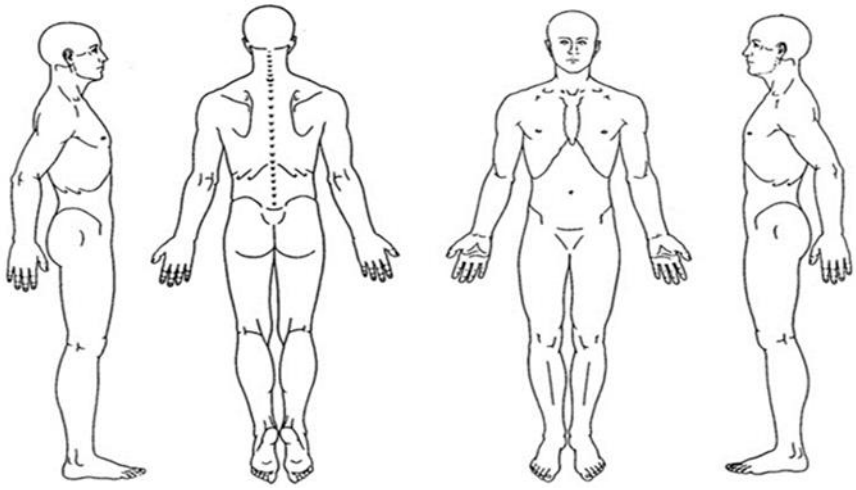
_____

_____

Have you had acupuncture treatment before? □ Yes □ No

Pain related issues

Indicate painful or distressed areas. Please **rate pain** on a scale of 1 (No pain) to 10 (Worst pain).



□ **Injury history**
□ **Pain gets worse** when cold / rainy / hot / humid/ tired/ moving / staying still/ at night / in the morning.
□ **Nature of pain:** Severe / Sharp / Stabbing / Dull / Cold / Hot / Aching / Throbbing / Sore

List any major disease or illness in your immediate family and indicate family member:

_____

_____

List all **medications or supplements**, including herbs and vitamins you are currently taking (**dose and brand**):

_____

_____

Occupation:_____

Do you have a regular exercise program? _____ Please describe. _____

_____

_____

Are you on a restricted diet? _____What kind? _____

_____

How much sugar/dessert do you eat per week? _____

_____

How much dairy do you eat per week? _____

_____

How many packs of cigarettes do you smoke per week/smoking history? _____

How much coffee, tea, or cola do you drink per week? _____

_____

How much alcohol do you drink per week? _____

Do you do any drugs? How much per week? Drug history? _____

_____

Do you have any food that causes trouble? _____

_____

What are the **main causes of your stress**? Have you experienced **major stress in the last 12 months**? (for example, death in the family, divorce, bankruptcy) _____

_____

Women Only

Are you pregnant now? □ Yes □ No

Last period date: _____/_____/_____

Number of children: _____

Number of pregnancies: _____

Age of first period: _____

Age of menopause (if applicable): _____

Birth control method: _____

□ Contraceptive pill history

a. from___/___/___ to___/___/___

b. from___/___/___ to___/___/___

c. from___/___/___ to___/___/___

□ IUD history

a. from___/___/___ to___/___/___

b. from___/___/___ to___/___/___

c. from___/___/___ to___/___/___

Patient Medical SYMPTOMS

Below are a series of health symptoms. Please check boxes with a **tick** for present symptoms and a **cross** for past symptoms. Please leave the box blank if you have never experienced this symptom.

Hot and Cold	Thirst	Sweat	Skin
☐ Cold hands/lower abdomen/feet ☐ Hot hands/feet/face/body ☐ Heat/Cold intolerance ☐ Face/body flushing ☐ Sensitive to light/sunlight	☐ Frequent thirst ☐ Not thirsty ☐ Drink cold water ☐ Thirst without desire to drink ☐ Dry mouth/throat ☐ Bitter taste in the mouth	☐ Sweat easily ☐ Hardly sweat ☐ Night sweat ☐ Damp hands or feet ☐ Areas that sweat the most: _____	☐ Dry Skin ☐ Acne ☐ Easy bruising or bleeding ☐ Eczema/Skin rashes ☐ Psoriasis ☐ Rosacea
Urination	**Sleep**	**Emotional**	**Chest**
☐ Frequent/Urgent urination ☐ Pain with urination ☐ Urination at night ☐ Dribbling urination ☐ Incontinence ☐ Difficulty starting urine ☐ Blood/cloudy/dark/smelly urine ☐ Recurrent urinary tract infections	☐ Hard to fall asleep ☐ Waking during the night ☐ Dream disturbed sleep ☐ Waking un-refreshed ☐ Kicking blankets away while sleeping ☐ Snoring ☐ Move around a lot while asleep	☐ Depressed feeling or teary ☐ Easily anxious ☐ Easily nervous ☐ Easily frustrated or angry ☐ High stress levels ☐ Scared and frightened easily	☐ Palpitation ☐ Shortness of breath ☐ Chest discomfort/pain ☐ Hypochondriac pain ☐ Frequent sighing ☐ Persistent cough
Bowel/Intestinal	**Digestion**	**Head**	**Body**
☐ Take supplement for bowel motion ☐ Bowel movement _____ time(s) per _____ day(s) ☐ Dry, hard/ pebble-like stool ☐ Loose or watery stool ☐ Loose stool in early morning ☐ Undigested food in stool ☐ Haemorrhoid history ☐ Dark brown stool ☐ Golden coloured stool ☐ Smelly stool/fart	☐ Great appetite ☐ Tend to eat constantly ☐ Bloating/burping ☐ Gassiness/flatulence ☐ Indigestion ☐ Nausea ☐ Abdominal pain ☐ Food intolerance ☐Reflux/heartburn ☐ Tummy pain with cold food or drink	☐ Dizziness ☐ Headache/migraine ☐ Eye pain/sleep/itchy/red ☐ Mouth ulcer/Cold sores ☐ Dry nasal mucus ☐ Tinnitus/ Hearing loss ☐ Ear infection ☐ Sore throat ☐ Sneezing/wheezing ☐ Runny/ stuffy nose ☐Nose bleeding	☐ Gain weight easily without eating much ☐ Don't gain weight with lots of food ☐ Body feels heavy or more painful when weather is cold or wet ☐ Swelling or puffiness ☐ Numbness ☐ Fatigue/poor energy
Menstruation related symptoms (women only)	**Menstruation (women only)**	**Female Specific Health**	**Male Specific Health**
☐ Depressed or teary ☐ Anxious or irritable ☐ Feeling aggressive or angry ☐ Breast tenderness ☐ Food cravings ☐ Bloating ☐ Back pain ☐ Abdominal pain/cramps ☐ Headaches or migraines ☐ Skin troubles ☐ Low energy ☐ Swollen body parts ☐ Loose stools ☐ Nausea	**Average days in flow**: _____ **Average cycle length:** _____ **The color of period is**: ☐ red ☐ dark red ☐ bright red ☐ light brown ☐ brown ☐ Irregular cycles ☐ Heavy blood flow/flooding ☐ Very light blood flow ☐ Bleeding between periods ☐ Spotting before/after bleed ☐ Passing of blood clots **Vaginal discharge**: ☐ Clear ☐ Sticky ☐ White ☐ Creamy ☐ Translucent white ☐ Watery ☐ Yellow ☐ Odourous ☐ Big amount	☐ Thrush ☐ Genital herpes ☐ Sexually transmitted disease ☐ Burning or itching pain on genitals ☐ Endometriosis ☐ Cyst ☐ Fibroids ☐ PCOS ☐ Vaginal dryness ☐ Low libido ☐ Excessive libido ☐ Painful intercourse ☐ Bleeding after intercourse ☐ Miscarriage history ☐ Prolapse	☐ Wet dreams ☐ Low libido ☐ Premature ejaculation ☐ Difficulty maintaining erection ☐ Genital rash or irritation ☐ Painful or swollen testicles ☐ Discharge ☐ Thrush ☐ Painful intercourse ☐ Burning or itching pain on genitals ☐ Genital herpes ☐ Sexually transmitted disease