

ACUPUNCTURE FILE

file no. : _____

CONFIDENTIAL QUESTIONNAIRE OF INTRODUCTION

Last Name: _____ First name: _____

Sex: M ☐ F ☐ Birth date: Day _____ Month _____ Year _____

Address: No: _____ Street: _____ App.: _____ City: _____

Postal Code: _____ Tél. : Res.: _____ Work. : _____ (Ext.) _____

Parent (Guardian): _____ Medicare No. : _____ - _____ - _____

CSST: ☐ file no. _____ SAAQ: ☐ file no. _____

MOTIVE FOR VISIT: _____

DATE : _____

day month year

MEDICAL HISTORY

1. Are you presently under a doctor's care?

YES ☐ NO ☐

If yes:

Last name: _____ First name: _____ Speciality: _____

Tel.: _____ Ext. _____

His diagnosis : _____

Prescribed treatment: _____

Treatment's reaction: _____

2. Have you been under health professional' care?

YES ☐ NO ☐

If yes:

Last name: _____ First name: _____ Speciality: _____

Tel.: _____ Ext.: _____

Received treatments: _____

Treatment's reaction: _____

Last name: _____ First name: _____ Speciality: _____

Tel.: _____ Ext.: _____

Received treatments: _____

Treatment's reaction: _____



This form is approved by the Ordre des acupuncteurs du Québec

3. Are you suffering or have you ever suffered from?

	YES	NO		YES	NO
* Heart disease (stroke, angina, valvular problems, murmur).....	☐	☐	* Diabetes	☐	☐
* Are you wearing a pacemaker?.....	☐	☐	* Thyroid problems.....	☐	☐
* High ☐ Low ☐ blood pressure	☐	☐	* Epilepsy	☐	☐
* Prolonged bleeding	☐	☐	* Nervous disorders	☐	☐
* Anemia	☐	☐	* Frequent headaches	☐	☐
* Lung problems	☐	☐	* Dizzy spells, fainting spells	☐	☐
* Tuberculosis	☐	☐	* Earaches	☐	☐
* Asthma	☐	☐	* Eye problems	☐	☐
* Hay fever.....	☐	☐	* Skin disease.....	☐	☐
* Do you have any of the following allergies?			* Arthritis.....	☐	☐
Food	☐	☐	* Venereal disease (V.D)	☐	☐
Medication.....	☐	☐	* Do you have AIDS symptoms?.....	☐	☐
* Digestive problems	☐	☐	* Are you an AIDS virus carrier?	☐	☐
* Stomach ulcer.....	☐	☐	* Have you ever had radiotherapy or / and chemotherapy treatments (tumor)?	☐	☐
* Liver disease (hepatitis: virus A, B, C, cirrhosis, cholesterol)	☐	☐	* Are you pregnant?.....	☐	☐
* Kidney disease	☐	☐	* Are you wearing any prosthesis: joints?	☐	☐
			: breast?... ..	☐	☐
			* Are you addicted to?		
			alcohol ☐ drug ☐ tobacco ☐ caffeine ☐		

* Where you ever hospitalized or have undergone surgery? If so indicate which ones and when?

	19
	19
	20
	20

4. Are you presently taking?

anticoagulants? ☐ YES ☐ NO

corticosteroid? ☐ YES ☐ NO

5. Are you presently taking drug or medication?

If so, which? _____
