

# Patient Information Sheet

Name: patName Date of Birth (day/month/year): patBirthdate.default

Address: patStreetAddress

City: patCityAddress Province: patProvince Country:                      Postal Code: patPostalCode

Telephone: Home ...mePhone.default Office: ...ssPhone.default Fax:                      Cell: ...obilePhone.default

Occupation: \_\_\_\_\_ Smoking: ☐ Yes ☐ No # of cigarettes/day: \_\_\_\_\_

Marital Status and # of Children: \_\_\_\_\_

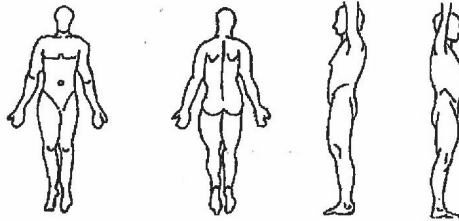
Family Doctor's Information: patMdName , patMdPhysNum , patMdAddress

Referring Doctor Information: currMdName , currMdPhysNum , currMdAddressLabel

Please answer the following questions:

1. What are the main reasons you wish to see the Doctor? ☐ Pain ☐ Fatigue ☐ Sleep Problems  
☐ Menstrual Problems ☐ Other Problems (Please Specify)

2. Please use the following drawings to mark the areas where you have pain:



3. What is your level of pain:

Today: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

General:  $\square_0 \square_1 \square_2 \square_3 \square_4 \square_5 \square_6 \square_7 \square_8 \square_9 \square_{10}$

4. Mark the treatment that you have received so far for your pain/fatigue or other problems?

☐ Medication    ☐ Physical Therapy    ☐ Chiropractic    ☐ Osteopathy    ☐ Relaxation

☐ Other (please specify)

5. So far, which treatments have benefited you the most? \_\_\_\_\_

6. List all of the medications and supplements you are taking, or have taken recently:

- ### 7. What do you expect from the Contemporary Acupuncture Treatments?

8. If you have several symptoms, what is your wish list?