NATURAL WELLNESS CENTRE

CONFIDENTIAL PATIENT RECORD

recent
patient photo

Date: _____

Sex: ☐ male ☐ female

Patient Name:_____
(last name) (first) (initial)

Present age: _____

Email: _____

Height: _____

Address: _____

Weight: _____

City: _____ Province: _____

/ /
month / day /year
Birthday

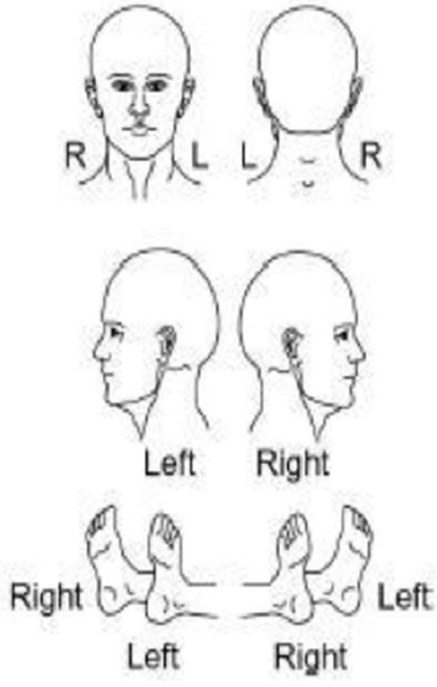
Postal Code _____

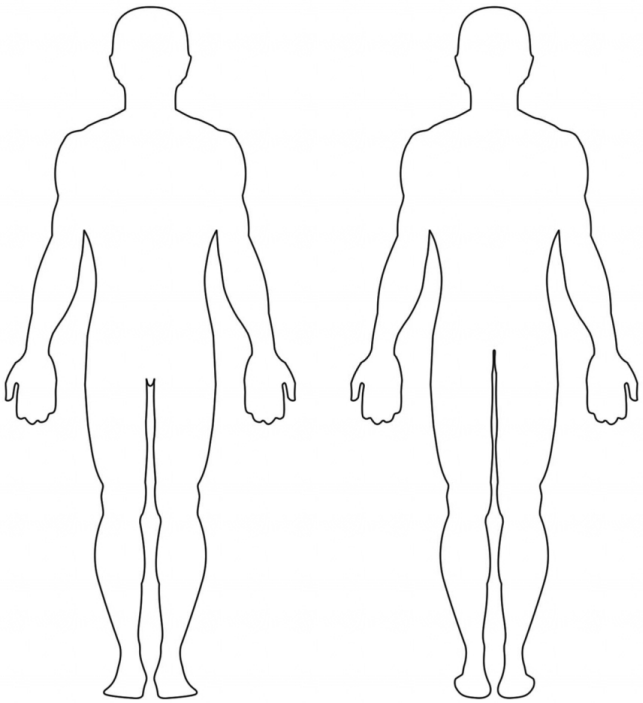
( ) - ( ) - ( ) - ( ) -
home phone work phone cell phone other

How did you find out about the Natural Wellness Centre?

Why have you come to the Natural Wellness Centre? _____

Where are your concerns?





Front Back

What other concerns do you have about your health? _____

☐	Medical diagnosis for main concern?	☐	Are you or could you be pregnant now?
☐	Under the care of a specialist?	☐	Recent physical / blood test / lab test
☐	Have you had acupuncture before?	☐	HIV+, Hepatitis or other blood/fluid borne illness?

Medications you take now: (list them with dosages)

List your daily or weekly quantity:

Alcohol		Smoking	
Coffee		Recreational drugs	

Do you sleep well each night? Never ☐ Rarely ☐ Mostly ☐ Always ☐

Do you awake feeling rested and refreshed?
Never ☐ Rarely ☐ Mostly ☐ Always ☐

Do you eat three meals a day? Yes ☐ No ☐
Are your mealtimes regular? Yes ☐ No ☐
Do you frequently eat fast foods? Yes ☐ No ☐
Are you under high mental or emotional stress? Yes ☐ No ☐
Are you constantly exposed to a high chemical environment? Yes ☐ No ☐

Scale your physical energy: Terrible ☐ Below my liking ☐ Normal or Good ☐
Scale your emotional wellbeing: Poor ☐ Average ☐ Good/no concerns ☐
Scale your stress level: Terrible/unusually high ☐ High but manageable ☐ Normal/no concerns ☐

What do you do for exercise? _____

Hours per day spent doing the following:

	Reading		Working on computer		Non-work screen time
	Homework		Housework		Job
	Sleeping		Exercise		Yard Work
	Other				