Patient Information Form

Caesarea Pain Centre

Dr. Ayelet Goldman-Riddle, D.O.M. (Canada), L.Ac.

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential.

If you have questions, please ask. Thank you and the best of health!

Personal:

*Full name:*_____ *Sex: F* ☐ *M* ☐

*Date of birth:*_____ *I. D. number:* _____

Address: _____

Main phone #: _____

*Cell phone #:*_____

*E-mail address:*_____

Allow email contact by Dr. Goldman-Riddle: ☐ *Yes* ☐ *No*

*Marital status:*_____ *Number of children:*_____

*Occupation:*_____

Do you usually work ☐ *indoors* ☐ *outdoors?*

Occupational stress (chemical, physical, psychological, etc): _____

_____

Why are you here today?:

_____

What diagnosis, if any, have you received for this condition?: _____

_____

When did this begin?: _____

*What do you think are the causes:*___ _____

How does this condition interfere with your daily activities (work, sleep, sex, etc.)?: _____

What other treatments have you tried?: _____

_____

*What makes this condition worse?:*_____

What makes this condition better?: _____

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Is there anybody in your family with the same/similar problem?: _____

*Remarks and additional information:*_____

_____

_____

Medical Profile:

*Height:*_____ *Weight now:*_____ *Weight one year ago:*_____

Weight maximum: _____*Year :*_____

Medical History *(Please include the month/year when the event occurred or when the diagnosis was established):*

Surgeries: _____

Hospitalization: _____

Significant trauma: *(auto accidents, sports injuries, etc):* _____

_____

Allergies: *(drugs, chemicals, foods, environmental):*_____

_____

Medicines *taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):* _____

_____

_____

Have you or any immediate family member ever suffered from:

☐ *Cancer (what type)*	☐ *Breathing problems*
☐ *Tuberculosis*	☐ *Diabetes*
☐ *Heart disease*	☐ *High cholesterol*
☐ *Hepatitis*	☐ *Digestive disorders*
☐ *High blood pressure*	☐ *Thyroid disease*
☐ *Venereal disease*	☐ *HIV*
☐ *Emotional disorders*	☐ *Seizures*
☐ *Alcoholism*	☐ *Anemia*
☐ *Arthritis*	☐ *Depression or anxiety*

☐ *Other*_____

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Habits:

Do you smoke?: ☐ *Yes* ☐ *No*

Amount per day?: _____ *Since when?:*_____

*Please describe any use of drugs for non-medical purposes:*_____

_____

Do you exercise regularly?: ☐ *Yes* ☐ *No. Please describe your exercise program:* _____

How many hours do you sleep in general?: _____

What time do you usually go to bed?: _____

Diet:

How much coffee do you drink?: _____*cups/day*

Cola: _____*number/day* *Tea:* _____ *cups/day*

What kind of alcoholic beverages do you usually drink, if any?: _____

Average number of drinks/week?: _____

*How much water do you drink per day?:*_____

Are you a vegetarian?: ☐ *Yes* ☐ *No* ☐ *Yes, but not so strict*

Do you eat a lot of spicy food?: ☐ *Yes* ☐ *No*

Please describe your average daily diet (Please be as specific as possible):

*Morning:*_____

_____

*Afternoon:*_____

_____

Evening: _____

_____

*Snacks:*_____

_____

Remarks and additional information (e.g. diet): _____

_____

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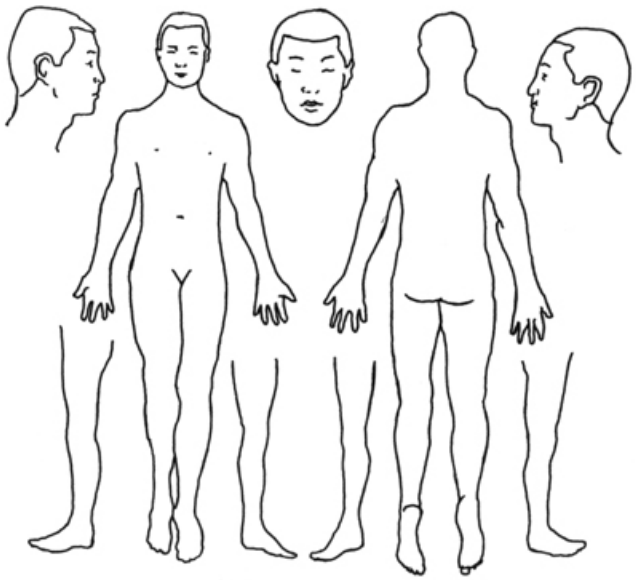
Please indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions:

General :

☐ *Poor appetite* ☐ *Poor Sleep* ☐ *Fatigue* ☐ *Fevers* ☐ *Chills* ☐ *Night sweats*

☐ *Sweat easily* ☐ *Tremors* ☐ *Poor balance* ☐ *Bleed or bruise easily*

☐ *Change in appetite* ☐ *Weight loss* ☐ *Weight gain*

☐ *Peculiar tastes* ☐ *Cravings* ☐ *Strong thirst (cold or hot drinks)*

☐ *Desire hot food* ☐ *Desire cold food*

☐ *Localized weakness* ☐ *Sudden energy drop (What time of day? _____)*

Favorite time of year _____ Worst time of year _____

Skin & Hair :

☐ *Rashes* ☐ *Ulcerations* ☐ *Hives* ☐ *Itching* ☐ *Eczema*

☐ *Pimples* ☐ *Acne* ☐ *Dandruff* ☐ *Dry skin* ☐ *Recent moles* ☐ *Loss of hair*

☐ *Purpura* ☐ *Change in hair or skin texture* ☐ *Other?_____*

Respiratory :

☐ *Cough* ☐ *Coughing blood* ☐ *Wheezing* ☐ *Difficulty breathing*

☐ *Bronchitis* ☐ *Pneumonia* ☐ *Chest pain*

☐ *Production of phlegm – What color? _____*

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Musculoskeletal :

☐ *Joint disorders* ☐ *Muscle weakness* ☐ *Muscle Pain/soreness* ☐ *Tremors*

☐ *Swelling of hands/feet* ☐ *Difficulty walking* ☐ *Spinal curvature*

☐ *Back pain* ☐ *Hernia* ☐ *Cold hands/feet* ☐ *Numbness* ☐ *Tingling*

☐ *Neck tightness* ☐ *Neck pain* ☐ *Shoulder pain* ☐ *Hand/wrist pain*

☐ *Hip pain* ☐ *Knee pain* ☐ *Joint Sprain* ☐ *Other?*_____

Head, Eyes, Ears, Nose, and Throat :

☐ *Dizziness* ☐ *Concussions* ☐ *Migraines* ☐ *Glasses/lens* ☐ *Eye strain*

☐ *Eye pain* ☐ *Color blindness* ☐ *Night blindness* ☐ *Poor vision* ☐ *Cataracts*

☐ *Blurry vision* ☐ *Earaches* ☐ *Ringing in ears* ☐ *Poor hearing*

☐ *Spots in front of eyes*

☐*Sinus problems* ☐ *Nose bleeding* ☐ *Sore throat* ☐ *Grinding teeth*

☐ *Dental problems* ☐ *Facial pain*

☐ *Jaw clicks* ☐ *Sores on lips/tongue* ☐ *Difficulty swallowing* ☐ *Other?*_____

Cardiovascular :

☐ *High blood pressure* ☐ *Low blood pressure* ☐ *Chest pain* ☐ *Palpitation*

☐ *Fainting*

☐ *Phlebitis* ☐ *Irregular heartbeat* ☐ *Rapid heartbeat* ☐ *Varicose veins*

☐ *Other?*_____

Gastrointestinal :

☐ *Nausea* ☐ *Vomiting* ☐ *Diarrhea* ☐ *Constipation* ☐ *Gas*

☐ *Belching* ☐ *Black stools* ☐ *Blood in stools* ☐ *Indigestion* ☐ *Bad breath*

☐ *Rectal pain* ☐ *Hemorrhoids* ☐ *Abdominal pain/cramps*

☐ *Gallbladder problems* ☐ *Parasites* ☐ *Chronic laxative use*

Bowel movements: Frequency _____ _____*Color* _____

Texture/ Form _____

Neuro-psychological

☐ *Loss of balance* ☐ *Lack of coordination* ☐ *Depression* ☐ *Anxiety* ☐ *Stress*

☐ *Bad temper* ☐ *Bi-polar*

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Genito-urinary

☐ *Kidney stones* ☐ *Painful urination* ☐ *Frequent urination* ☐ *Blood in urine*

☐ *Urgency to urinate* ☐ *Unable to hold urine* ☐ *Dribbling* ☐ *Pause of flow*

☐ *Frequent urinary tract infection* ☐ *Genital pain* ☐ *Genital itching*

☐*Genital rash* ☐ *STD* ☐ *Other?*_____

Female :

☐ *Frequent vaginal infections* ☐ *Pelvic infection* ☐ *Endometriosis*

☐ *Fibroids* ☐ *Ovarian cysts* ☐ *Irregular periods* ☐ *Clots*

☐ *Vaginal/genital discharge* ☐ *Pain/cramps prior/during periods*

☐ *Breast tenderness* ☐ *Breast Lumps* ☐ *Fertility Problems* ☐ *Hot flashes*

☐ *Moodiness related to periods*

_____ *Number of pregnancies* _____ *Number of births* _____*Miscarriages*

_____*Abortions* _____ *Premature births* _____ *C-sections*

_____ *Difficult deliveries*

Age of first period _____ *First date of last period* _____

Duration of periods _____*days, cycle* ____ *days*

Do you practice birth control ? ☐ *Yes* ☐ *No.*

If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long?

_____

Male:

☐ *Prostate problems* ☐ *Discharge* ☐ *Erectile dysfunction* ☐ *Ejaculation problems*

☐ *Frequent seminal emission* ☐ *Fertility problems* ☐ *Painful/swollen testicles*

☐ *Other:*_____

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Are there any other health issues you want to discuss with the Doctor?

_____

_____

_____

Have you ever been treated by Acupuncture and/or Chinese Herbs before?:

☐ *Yes* ☐ *No*

How did you find out about the clinic?:

☐ *Referred by (name):* _____

☐ *Caesarea News* ☐ *Walk by* ☐ *Internet/Website*

☐ *Other (please specify):* _____

I have completed this form correctly to the best of my knowledge.

By signing below, I declare that I come to the treatments out of my free will and that I agree to receive Acupuncture treatments and Chinese Herbal Therapy from Dr. Ayelet Goldman-Riddle. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

Name: _____Signature:_____

I.D. Number_____Date:_____

☐ *Adult Patient* ☐ *Parent or Guardian* ☐ *Spouse*