Dr. Kent Farnsworth, Dr.TCM, R.Ac.
Total Health Clinic
735 Victoria St.
Kamloops, BC V2C 2B5
250-374-9700

Please check all that apply:

Lung & Large Intestine	Kidney & Bladder	Liver & Gallbladder	Heart & Small Intestine
☐ Allergies	☐ Adrenal Weakness	☐ Anger/Irritability	☐ Abdominal Pain
☐ Arm/Wrist/Elbow Pain	☐ Back/Hip/Knee Pain	☐ Breast Tenderness	☐ Anaemia
☐ Asthma/Bronchitis	☐ Bladder Infec./Control	☐ Brittle/Coarse Nails/Hair	☐ Anxiety/Dread
☐ Constipation	☐ Brittle Bones	☐ Bruising	☐ Digestive Troubles
☐ Cough/Sneeze/Phlegm	☐ Cold Hands/Feet	☐ Depression	☐ Dream Dist.Sleep
☐ Eczema/Psoriasis/Rash	☐ Dark/Puffy Around Eyes	☐ Distention/Bloating	☐ Elbow/Shoulder Pain
☐ Flatulence	☐ Depression/Fear	☐ Eye/Vision Problems	☐ Hearing Problems
☐ Frequent colds	☐ Edema/Water retention	☐ Flatulence	☐ Heart Problems
☐ Frontal/Sinus HA	☐ Hot Flashes	☐ Headaches	☐ Hot Flashes
☐ Grief/Sadness	☐ Impotence/Libido	☐ Haemorrhoids	☐ Hot/Painful Joints
☐ Lethargy/Fatigue	☐ Infertility/Sterility	☐ Indigestion	☐ Lack of Joy/Humour
☐ Loose Stools	☐ Lethargy/Fatigue	☐ Irritable Bowel	☐ Mouth/Tongue Sores
☐ Mucus	☐ Loss/Thinning Hair	☐ IT Band Tightness	☐ Neck Pain
☐ Nasal problems	☐ Night Sweats	☐ Lack of Flexibility	☐ Palpitations
☐ Shoulder pain	☐ Poor Memory	☐ Menstrual Irregularity	☐ Poor Circulation
☐ Sinusitis	☐ Premature Grey	☐ Migraines	☐ Restlessness
☐ Smell Problems	☐ Sciatica/Back Pain	☐ Nausea/Vomiting	☐ Sleep Problems
☐ Stiff Joints/Neck	☐ Sore throat in a.m.	☐ PMS	☐ Tongue/Speech
☐ Sweating problem	☐ Tight Hamstrings	☐ Stiff Neck/Shoulders	☐ Upper Back Pain
☐ Weak Voice	☐ Tinnitus	☐ Tension/Cramps	☐ Urine problems
☐ Wheezing/SOB	☐ Urine Problems	☐ Tinnitus	☐ Wrist Pain
☐ Other ___________	☐ Other ___________	☐ Other ___________	☐ Other ___________

Spleen & Stomach

- ☐ Abdominal Pain
- ☐ Aching/Heavy Limbs
- ☐ Anaemia
- ☐ Appetite/Digestive Prob.
- ☐ Belching
- ☐ Bruise Easily
- ☐ Colic/Indigestion
- ☐ Difficulty Focusing
- ☐ Distension/Bloating
- ☐ Headaches
- ☐ Heaviness at Head
- ☐ Haemorrhoids
- ☐ Hiccups
- ☐ Irritable Bowel
- ☐ Lethargy/Fatigue
- ☐ Loose Stools
- ☐ Muscle Weakness
- ☐ Nausea/Vomiting
- ☐ Poor Memory
- ☐ prolapse
- ☐ Worry/Over-Thinking
- ☐ Other ___________

On a scale of 1-10, how would you rate your daily energy level? (10 being best) ________

Occupation:____

Do you enjoy your work? ☐Yes ☐No Explain: ________________________________

How many hours per week do you work? _______________/week.

Is it stressful? ☐Yes ☐No Explain: ____

What are your duties? ____

Please describe, in general, what you eat? ____________________________________

What do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.) ____

____

____

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e., irritable, worrier, anxious, sad, impatient stressed, etc.)? ________________________

____

____

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? ☐Yes ☐No

If Yes, briefly explain for what condition or reasons and the year:

____

Do you participate in the following physical activities? ☐Yes ☐No

If Yes, how often?

☐Yoga___ ☐Running___ ☐Walking___ ☐Gym___ ☐Other

☐Biking ___ ☐Swimming___ ☐Gym___ ☐Fitness Class___ _______

How did you hear about Farnsworth Acupuncture? (Internet, Friend, Health Practioner, Doctor, yellow Pages, Info Tel.)

____

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General Medical History

Date: (yy-MM-dd)

Mr.☐ Ms.☐ Mrs.☐ Dr.☐ (Please check one)

Last Name:	**First Name:**

Birthdate: (yy-MM-dd) Age:

Check # of preferred contact

Address:	Home #:
City:	Work #:
Province:	Mobile #:
E-mail:	Occupation:

Reason for Visit:

Have you had Acupuncture before? Yes ☐ No ☐
Chinese Herbal Medicine Yes ☐ No ☐

Family Physician Name:	Family Physician #:
Western Medical Diagnosis (if applicable):	
Other Medical Treatments Received: **Physiotherapy ☐ / Massage ☐ / Naturopathy ☐ / Chiropratic ☐ / Other: ____________**	

Please indicate with a **'P'** (past), **'C'** (current), **'F'** (family) if any of the conditions below apply:

___ Heart Conditions	___ Stroke	___ High Blood Pressure	___ Low Blood Pressure
___ Diabetes	___ Deep Vein Thrombosis	___ Neurological	___ Spinal or Head Injury
___ Respiratory Condition	___ Kidney Disorder	___ Cancer	___ Hepatitis
___ HIV / AIDS	___ Sprain / Strain / Fracture	___ Osteoporosis	___ Headaches / Migraines
___ Jaw Pain	___ Arthritis	___ Dizziness / Fainting	___ Contagious illness
___ Skin Condition	___ Digestive Problems	___ Haemophiliac	___ Wear a Pacemaker
___ Lung Condition	___ Epilepsy	___ Possibility of Pregnancy	___ Upcoming Surgeries

On the figures below, please circle the areas of concerns / pain:

Sensations / Pain characteristics (check):
Sharp☐ Burning☐ Moving☐ Tigling☐ Dull☐ Severe☐
Stabbing☐ Shooting☐ Throbbing☐ Numbness☐

What relieves the pain (ice, rest, activity, massage, heat,...)?
____

What aggravates the pain (weather, heat, cold, rest, activity...)?
____

Please list what you are currently taking (if applicable):

Prescription medication or over-the-counter drugs:	**Herbal medicine and other supplements:**
1. ____________	1. ____________
2. ____________	2. ____________
3. ____________	3. ____________
4. ____________	4. ____________
5. ____________	5. ____________
6. ____________	6. ____________

Please list any allergies
(food, drugs, environmental, etc.):

1. ____________
2. ____________
3. ____________
4. ____________

Do you use the following?
If Yes, how often?

☐Cigarettes _____
☐Alcohol _____
☐Drugs _____
☐Coffee _____
☐Pop _____