INVITATION TO HEALTH
Integrative Medicine

Sage Acupuncture Pty Ltd
@ Invitation To Health
256 Henry Parry Drive
Wyoming NSW 2250
Phone 02 4322 0700
www.sageacupuncture.com.au
ABN 89 622 578 385

NEW PATIENT FORM

Personal Details

Title | Given Name | Surname

Home Address

Address (continued) | Postcode

Mobile Phone | Other Phone

Email

Age | Date of Birth | Occupation

Private health insurance fund

Or ☐ None

Emergency Contact

Contact Name

Contact Phone

Relationship to Me

My General Practitioner

GP's Name

GP's Location

May we contact your GP about your treatment?

☐ Yes ☐ No

I heard about you from:

Please tick any that apply:

- ☐ Someone who is a patient
- ☐ A practitioner who referred me
- ☐ A friend or family member
- ☐ Google or other search engine
- ☐ hotdoc
- ☐ Somewhere else
- ☐ Invitation to Health newsletter or email
- ☐ Invitation to Health website
- ☐ Sage Acupuncture website
- ☐ Magazine or newspaper

Consent to Treatment

Welcome to Sage Acupuncture at Invitation To Health. The therapies we provide have a long history of safe practice, however there are always some risks associated with any sort of treatment. This practice may use Acupuncture and/or Chinese herbal medicine in your care.

Please tell your practitioner if you do not want a particular kind of therapy.

As with most therapies, there is a small risk of adverse reactions. With acupuncture, you may experience itchiness, pain, bruising, dizziness, numbness or an aggravation of your condition.

The best way to minimise risks is to answer all questions about your health completely and honestly. We will explain all treatments to you before we commence them but please ask if you require further explanation or have any questions or worries.

As your appointment time is specially reserved for you, a $45 administration fee will apply for a cancellation of appointment with less than 48 hours' notice.

I understand the risks outlined above and agree to undergo treatment.

I understand that an anonymised treatment history may be shared with other Medical professionals. Patient identities always remain confidential and will never be shared.

Full Name

Today's Date

Signature

Major Complaints

What are the major problems you would like to be treated today, and when did they occur?

What is the problem?

When did it start?

What is the problem?

When did it start?

What is the problem?

When did it start?

Current Treatment

Are you receiving any other treatments? Please provide details:

Or ☐ None

Expectations

What would you like to achieve from today's treatment?

Medications

What medications (both prescribed and over-the-counter) are you taking?

Medicine name (eg. Coversyl)	Dosage (eg. 10mg once a day)	Disorder (eg. high blood pressure)
Medicine	Dosage	Disorder
Medicine	Dosage	Disorder
Medicine	Dosage	Disorder

Vitamins and mineral supplements

Are you taking any vitamins or mineral supplements? Please provide details of brand and strength:

Or ☐ None

Prolonged or regular use

Please indicate if you regularly take or have taken any of these classes of drugs:

- ☐ over the counter medications
- ☐ acid blocking drugs (Losec, Nexium, Pariet)
- ☐ steroids (Prednisone, inhalers)
- ☐ antibiotics
- ☐ antidepressants
- ☐ medical cannabis

Anything else that is relevant

Family Medical History

Please indicate if anyone in your family has ever had any of these conditions:

- ☐ diabetes
- ☐ hepatitis
- ☐ stroke
- ☐ heart disease
- ☐ kidney disease
- ☐ cancer
- ☐ asthma
- ☐ epilepsy/seizures
- ☐ mental illness
- ☐ allergies

Anything else that is relevant

Preventative & diagnostic testing

Have you had any of these tests in the last 2 years:

- ☐ skin check
- ☐ bone density
- ☐ hemoccult stool test for blood
- ☐ vaccination
- ☐ colonoscopy

Special conditions

We need to take special care with acupuncture if certain special conditions apply:

- ☐ bruise easily
- ☐ bleeding disorder
- ☐ suffer from fainting, dizziness, or epilepsy
- ☐ currently pregnant
- ☐ have an infectious disease

For Women for this would suggest asking an approximate date: please tick if you have done this in the past 1-2 years, write the approximate date if you know it.	
☐ PAP SMEAR	
☐ MAMMOGRAM	
*** BRING ALL SUPPLEMENTS/MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT***	

Past and Current Medical History

Check box if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months)

GASTROINTESTINAL	**CARDIOVASCULAR**	**METABOLIC**
☐ IRRITABLE BOWEL SYNDROME	☐ HEART ATTACK	☐ INSULIN RESISTANCE
☐ INFLAMMATORY BOWEL DISEASE	☐ STROKE	☐ HYPOTHYROIDISM (LOW THYROID)
☐ PEPTIC ULCER	☐ ELEVATED CHOLESTEROL	☐ HYPERTHYROIDISM
☐ GORD (REFLUX)	☐ ARRYTHMIA (IRREGULAR HEART RATE)	☐ POLYCYSTIC OVARIAN SYNDROME
☐ COELIAC DISEASE		☐ BULIMIA
☐ COLONOSCOPY	☐ HIGH BLOOD PRESSURE	☐ ANOREXIA
WHEN	☐ RHEUMATIC FEVER	☐ BINGE EATING DISORDER
☐ OTHER	☐ OTHER	☐ TYPE 1 DIABETES
		☐ TYPE 2 DIABETES
CANCER	**INFLAMMATORY/ AUTOIMMUNE**	☐ OTHER
☐ LUNG CANCER	☐ CHRONIC FATIGUE SYNDROME	
☐ BREAST CANCER	☐ GLANDULAR FEVER	**SKIN DISEASES**
☐ COLON CANCER	☐ HASHIMOTO OR GRAVES	☐ ECZEMA
☐ OVARIAN CANCER	☐ RHEUMATOID ARTHRITIS	☐ PSORIASIS
☐ PROSTATE CANCER	☐ LUPUS/SLE	☐ ACNE
☐ SKIN CANCER	☐ IMMUNE DEFICIENCY DISEASE	☐ MELANOMA
☐ OTHER	☐ FOOD ALLERGIES	☐ SKIN CANCER
	☐ ENVIRONMENT ALLERGIES	☐ OTHER
GENITAL AND URINARY	☐ MULTIPLE CHEMICAL SENSITIVITIES	
☐ KIDNEY STONES	☐ LATEX ALLERGY	**NEUROLOGIC/MOOD**
☐ GOUT	☐ OTHER AUTOIMMUNE	☐ DEPRESSION
☐ INTERSTITIAL CYSTITIS		☐ ANXIETY
☐ FREQUENT URINARY TRACT INFECTIONS	**RESPIRATORY DISEASES**	☐ BIPOLAR DISORDER
	☐ ASTHMA	☐ SCHIZOPHRENIA
☐ FREQUENT YEAST INFECTIONS	☐ CHRONIC SINUSITIS	☐ HEADACHES
☐ ERECTILE DYSFUNCTION	☐ BRONCHITIS	☐ MIGRAINES
☐ SEXUAL DYSFUNCTION	☐ EMPHYSEMA	☐ ADD/ADHD
	☐ PNEUMONIA	☐ AUTISM
MUSCULOSKELETAL OR PAIN	☐ TUBERCULOSIS	☐ MILD COGNITIVE
☐ OSTEOARTHRITIS	☐ SLEEP APNOEA	☐ PARKINSON'S DISEASE
☐ FIBROMYALGIA	☐ OTHER	☐ MULTIPLE SCLEROSIS
☐ CHRONIC PAIN		☐ SEIZURES
☐ OTHER	**PREVIOUS ACCIDENTS OR OPERATIONS**	☐ OTHER
	☐	☐ HEAD INJURIES- WHEN?
	☐	

Further Medical History

YOUR CHILDHOOD HISTORY	FOR WOMEN *OBSTETRIC HISTORY*	MENOPAUSE HISTORY
☐ EAR INFECTIONS	☐ VAGINAL DELIVERIES	☐ HORMONE REPLACEMENT THERAPY
	☐ MISCARRIAGE	
☐ RECURRENT STREP THROAT	☐ ABORTION	☐ CURRENTLY?
☐ STOMACH ACHES	☐ LIVING CHILDREN	☐ YEARS?
☐ OTHER CHILDHOOD ILLNESSES	☐ POST PARTUM DEPRESSION	☐ PAST?
	☐ PRE-ECLAMPSIA	WHEN?
DENTAL HISTORY	☐ GESTATIONAL DIABETES	
☐ SILVER MERCURY FILLINGS	☐ BREAST FEEDING	**LIFESTYLE AND SELF-CARE**
HOW MANY	HOW LONG?	
☐ GOLD FILLINGS	☐ ORAL CONTRACEPTIVE PILL AT ANY TIME?	☐ **Ex-Smoker**
☐ ROOT CANALS		☐ **Currently Smoking: how many per day**
☐ IMPLANTS	WHEN? HOW LONG FOR	
☐ TOOTH OR JAW PAIN	☐ C-SECTION	**SLEEP PATTERNS**
☐ BLEEDING GUMS		☐ HOURS SLEEP EACH NIGHT
☐ GINGIVITIS		☐ DO YOU WAKE OFTEN
		☐ DIFFICULTY GETTING TO SLEEP

Current Symptoms – Please tick if you have any of the following symptoms:

SKIN PROBLEMS	HEAD, EYES & EARS	CARDIOVASCULAR
☐ ACNE	☐ DISTORTED SMELL	☐ CHEST PAIN
☐ ATHLETE'S FOOT	☐ DISTORTED TASTE	☐ BREATHLESNESS
☐ BUMPS BACK OF ARM	☐ BAD BREATH	☐ PALPITATIONS
☐ CELLULITE	☐ EAR FULLNESS	☐ PAIN IN CALVES
☐ DANDRUFF	☐ EAR PAIN	☐ SWOLLEN ANKLES
☐ DARK CIRCLES UNDER EYES	☐ EAR RINGING	☐ VARICOSE VEINS
☐ EARS GET RED	☐ HEARING PROBLEMS	☐ LIGHT HEADEDNESS
	☐ RECURRENT SORE THROAT	☐ FAINTING
	☐ HOARSENESS	**RESPIRATORY**
☐ EASY BRUISING	☐ EYE PAIN/IRRITATION	☐ SNORING
☐ ECZEMA	☐ VISON DISTURBANCE	☐ COUGH
☐ HERPES – GENITAL	☐ SINUS	☐ COUGHING UP BLOOD
☐ COLD SORES	☐ MIRGAINE	☐ HAYFEVER
☐ HIVES	☐ HEADACHE	☐ SINUS FULLNESS
☐ JOCK ITCH	☐ NOISE SENSITIVE	☐ NASAL STUFFINESS
☐ CHANGE IN MOLES	☐ JAW PAIN	☐ NOSE BLEEDS
	☐ ITCHY EARS	BREATHE THRU MOUTH

Current Symptoms continued...

Skin problems continued…	NAILS	Respiratory continued ...
☐ OILY SKIN	☐ BITTEN	☐ POST NASAL DRIP
☐ RASH	☐ BRITTLE	☐ SHORTNESS OF BREATH
☐ SENSITIVE TO BITES	☐ FUNGUS	☐ AT REST
☐ SHINGLES	☐ RIDGES	☐ WITH EXERCISE
☐ SKIN ITCHING	☐ THICKENED	
☐ SKIN DRYNESS	☐ WHITE SPOTS/LINES	**ENDOCRINE/IMMUNE**
☐ STRONG BODY ODOUR	☐	☐ COLD HANDS/FEET
ITCHY ANUS OR VAGINA		☐ COLD/HEAT INTOLERANCE
DIGESTION		☐ FATIGUE
☐ BLOATING AFTER EATING	**MUSCLE/BONE**	☐ WEIGHT GAIN
☐ BLOOD IN STOOLS	☐ MUSCLE TWITCHING	☐ GET SICK A LOT
☐ BURPING	☐ MUSCLE PAIN	☐ SWOLLEN LYMPH NODES
☐ CONSTIPATION	☐ JOINT PAN OR SWELLING	☐ HAIR LOSS
☐ ANAL ITCHING	☐ JOINT STIFFNESS	
☐ DIARRHEA	☐ BACK PAIN	**URINARY**
☐ DIFFICULTY SWALLOWING/PAINFUL		☐ HESITANCY
☐ DRY MOUTH	**MOOD NERVES**	☐ FREQUENT UTI
☐ FISSURES	☐ DIFFICULTY CONCENTRATING	☐ PAIN/BURNING
☐ HEARTBURN (REFLUX)	☐ DIFFICULT WITH BALANCE	☐ URGENCY
☐ HAEMORRHOIDS	☐ DIFFICULTY WITH JUDGEMENT	☐ LEAKING
INTOLERANCE TO:	☐ DIFFICULTY WITH MEMORY	☐ BLOOD IN URINE
☐ LACTOSE	☐ DIZZINESS (SPINNING)	☐ FREQUENT URINATION
☐ ALL MILK PRODUCTS	☐ SUICIDAL THOUGHTS	
☐ GLUTEN	☐ DEPRESSION	
☐ CORN	☐ NUMBNESS	
☐ EGGS	☐ PANIC ATTACKS	
☐ FATTY FOODS	☐ ANXIETY	
☐ OTHER	☐ PHOBIAS/FEARS	
DIGESTION	☐ PARANOIA	
☐ YELLOW EYES/SKIN	☐ HELLUCINATIONS	**MALE REPRODUCTIVE**
☐ ABDOMINAL PAIN	☐ SEIZURES	☐ DISCHARGE FROM PENIS
☐ MUCOUS IN STOOLS	☐ TREMOR	☐ EJACULATION PROBLEM
☐ NAUSEA	☐ SLEEPNG PROBLEMS	☐ GENITAL PAIN
☐ STRONG STOOL ODOR	☐ MOTION OR CAR SICKNESS	☐ POOR LIBIDO (LOW SEX DRIVE)
☐ UNDIGESTED FOODS IN STOOLS	☐ FEELING 'OUT OF BODY'	☐ IMPOTENCE
☐ VOMITING	☐	☐ LUMPS IN TESTICLES
☐ UNINTENTIONAL WEIGHT GAIN	☐	☐
☐ FLOATING OR LIGHT-COLOURED STOOL	☐	☐

FEMALE REPRODUCTIVE	PREMENSTRUAL	MENOPAUSE- WHAT AGE:
☐ BREAST CYSTS	☐ BREAST TENDERNESS	☐ HOT FLUSHES
☐ BREAST TENDERNESS	☐ MOODS SWINGS	☐ VAGINAL DRYNESS
☐ OVARIAN CYST	☐ FOOD CRAVING	☐ PAINFUL SEX
☐ POOR LIBIDO (SEX DRIVE)	☐ SLEEP CHANGE	☐ DECREASED LIBIDO
☐ PELVIC PAIN	☐ FATIGUE	☐ WEIGHT GAIN
☐ INFERTILITY	☐ IRRITABILITY	☐ SLEEP DISTURBANCE
☐ VAGINAL DISCHARGE	**MENSTRUAL**	☐ MOOD DISTURBANCE
☐ VAGINAL ITCH	☐ CRAMPS	☐
☐ BLEEDING BETWEEN PERIODS	☐ HEAVY PERIODS	☐
PAINFUL SEXUAL INTERCOURSE	☐ IRREGULAR PERIODS/SPOTTING	☐
	☐ NO PERIODS	☐
	☐ CHANGE IN BOWEL HABIT WITH MENSES	☐

Nutrition and Diet History

Have you made any changes in your eating habits because of your Health ☐ YES ☐ NO.

Describe:

_____

CHECK ALL THAT APPLY PARTIALLY OR FULLY TO YOU:

☐ LOW FAT ☐ LOW CARBOHYDRATES ☐ HIGH PROTEIN ☐ LOW SODIUM ☐ DIABETIC
☐ NO DAIRY ☐ NO WHEAT ☐ GLUTEN RESTRICTED ☐ VEGETARIAN ☐ VEGAN

SPECIFIC PROGRAM FOR WEIGHT LOSS MAINTENANCE TYPE:

_____

☐ OTHER

_____

CHECK ALL THE FACTORS THAT APPLY TO YOUR CURRENT LIFESTYLE AND EATING HABITS:

☐ FAST EATER	☐ ERRACTIC EATING PATTERNS	☐ EAT TOO MUCH
☐ LATE NIGHT EATING	☐ TRAVEL FREQUENTLY	☐ EAT BECAUSE I HAVE TO
☐ EAT TOO LITTLE UNDER STRESS	☐ LOVE TO EAT	☐ EAT IN THE MIDDLE OF THE NIGHT
☐ EAT TOO MUCH UNDER STRESS	☐ HAVE A NEGATIVE RELATIONSHIP WITH FOOD	☐ RELIANCE ON CONVENIENCE ITEMS
☐ DO YOU COOK	☐ DO YOU ADD SALT TO FOOD	☐

STRESS/COPING Check all that apply**:**

☐ I AM SEEING/HAVE SEEN A PSYCHOLOGIST OR COUNSELLOR		
☐ I HAVE AN EXCESSIVE AMOUNT OR STRESS		
DAILY STRESSORS: RATE ON CALE OF 1-10 (10 IS WORST)		
☐ WORK	☐ FAMILY	☐ SOCIAL
☐ FINANCES	☐ HEALTH	☐ OTHER

I PRACTICE MEDITATION OR RELAXATION TECHNIQUE. HOW OFTEN?

Check all that apply**:**

☐ YOGA	☐ MEDITATION	☐ IMAGERY
☐ BREATHING	☐ TAI CHI	☐ PRAYER
☐ ORGANISED EXERCISE	☐ WALKING	☐ OTHER

Readiness to Change

RATE ON A SCALE OF: 5 being (very willing) and 1 (not willing)

In Order to improve your Health. How willing are you to?

Significantly modify your diet?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
Keep a record of everything you eat each day?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
Modify your lifestyle?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
Engage in Regular Exercise?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
Take several Nutritional supplements each day?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
Practice a relaxation technique?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
How confident are you of your ability to organise and follow through on the above health related activities?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	5 ☐ 4 ☐ 3 ☐ 2 ☐ 1☐

Exercise - Current Exercise Program

Activity	Type	How often each week	How long

Stretching:
Cardio/Aerobics:
Strength:
Other (Yoga, Pilates etc):
Sports or leisure activity:

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High
list problems that limit activity: _____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No
if yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No

Environmental or Other Exposures and Detox Assessment

ADVERSE REACTION TO	**HISTORY OF:**
☐ CAFFEINE	☐ JAUNDICE (TURNING YELLOW)
☐ IRRITABLE WIRED ACHES & PAINS	☐ GILBERT'S SYNDROME OR A LIVER DISORDER
☐ MONOSODIUM GLUTAMATE (MSG)	**EXPLAIN**
☐ ASPARTAME (NUTRASWEET)	
☐ BANANAS GARLIC ONION CHEESE	**EXPOSURE TO HARMFUL CHEMCIALS SUCH AS:**
☐ CITRUS FOODS CHOCOLATE ALCOHOL RED WINE	☐ HERBICIDES
☐ SULPHITE CONTAINING FOODS	☐ INSECTICIDES (FREQUENT VISITS OF EXTERMINATOR
☐ (WINE, DRIED FRUIT, SALAD BARS)	☐ PESTICIDES
☐ PRESERVATIVES (SODIUM BENZOATE)	☐ ORGANIC SOLVENTS
☐ OTHER	☐ HEAVY METALS
	☐ OTHER
YOU ARE AFFECTED BY	
	☐ CHEMICAL NAME/DATE/LENGTH OF EXPOSURE
☐ CIGARETTE SMOKE	
☐ PERFUMES/COLOGNES	
☐ AUTO EXHAUST FUMES	☐ DRY CLEAN YOUR CLOTHES FREQUENTLY
☐ OTHER	☐ LIVED OR WORKED IN A DAMP OR MOULDY ENVIRONMENT OR HAD OTHER MOULD EXPOSURE
	☐ DO YOU HAVE ANY PETS OR FARM ANIMALS
IN YOUR WORK OR HOME ENVIRONMENT ARE YOU	☐ ELECTROMAGNETIC RADIATION
EXPOSED TO:	☐ WORK WITH OIL BASED PAINT - ARTIST OR PAINTER
☐ CHEMICALS	☐ HISTORY OF DRINKING PROBLEM
☐ MOULD	SEE LIFESTYLESECTION FOR DETAILED QUESTIONS

NUTRITION AND DIET

HOW OFTEN DO YOU WEIGH YOURSELF?
☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ RARELY ☐ NEVER
DO YOU AVOID ANY PARTICULAR FOODS? ☐ YES ☐ NO
☐ IF YES, TYPE THE REASON
DO YOU GROCERY SHOP? ☐ YES ☐ NO

IF NO, WHO DOES THE SHOPPING?
DO YOU READ FOOD LABELS? ☐ YES ☐ NO
DO YOU COOK? ☐ YES ☐ NO
IF NO, WHO DOES THE COOKING:
HOW MANY MEALS DO YOU EAT OUT PER WEEK? 0-1 ☐ 1-3 ☐ 3-5 .☐ .>.5 MEALS PER WEEK ☐

Please list below the times you have the following meals, and what you would normally have for each meal

MEAL	TIME	WHAT WOULD YOU NORMALL EAT
Breakfast		
Morning Tea		
Lunch		
Afternoon Tea		
Dinner		
After Dinner		

What would you have for general snacks?

What types of food to you crave?

Are you frequently hungry?

Can you leave 3 to 4 hours between meals without needing to snack? (Not Including overnight)
☐ YES ☐ NO

*** PLEASE REMEMBER BRING ALL SUPPLEMENTS/MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT***