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?:*_____

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What makes this condition better?: _____
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)*
☐ *Tuberculosis*
☐ *Heart disease*
☐ *Hepatitis*
☐ *High blood pressure*
☐ *Venereal disease*
☐ *Emotional disorders*
☐ *Alcoholism*
☐ *Arthritis*
☐ *Breathing problems*
☐ *Diabetes*
☐ *High cholesterol*
☐ *Digestive disorders*
☐ *Thyroid disease*
☐ *HIV*
☐ *Seizures*
☐ *Anemia*
☐ *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?: _____

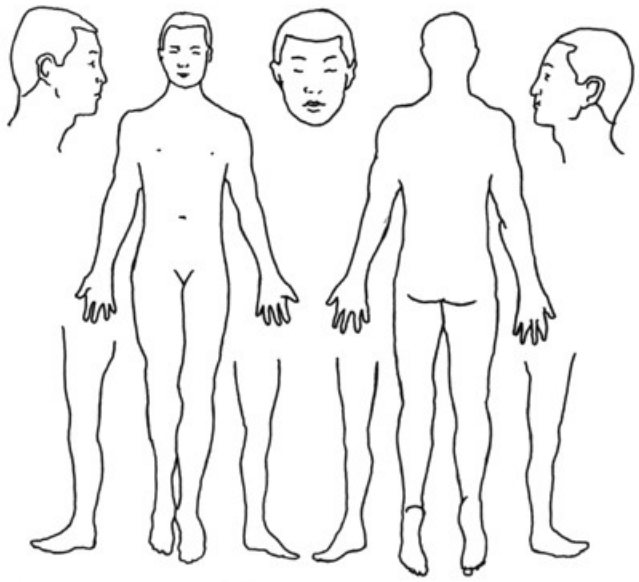
Average number of drinks/week?: _____

*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 indicate painful or distressed areas:



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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 _____

Respiratory :

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

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

☐ *Production of phlegm – What color? _____*

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?_____*

Cardiovascular :

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

☐ *Fainting*

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

☐ *Other?_____*

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Are there any other health issues you want to discuss?

_____

_____

_____

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):* _____

☐ *Facebook/Instagram* ☐ *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
Dr. Ayelet Goldman is a Doctor of Oriental Medicine (D.O.M) and not a Medical Doctor (MD). Receiving treatments from her does not wave the need (if there is any) to visit a Western Medicine Physician and not seeing one is the sole decision and responsibility of the patient. Any changes to recommendations made by Western Physicians should be made in coordination with them, including changes to medications, follow-up tests or any other recommendations.

Name: _____*Signature:*_____

*I.D. Number*_____*Date:*_____

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