



# K-W HOMEOPATHIC MEDICINE AND WELLNESS CLINIC

## NEW PATIENT INFORMATION

\*All information provided is kept in strict confidence

Date: \_\_\_\_\_

**ACUTE PATIENT**

<b>Name:</b>		
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	<b>Postal Code:</b>
<b>Home Phone:</b>	<b>Cell Phone:</b>	<b>Work Phone:</b>
<b>Weight:</b>	<b>Height:</b>	<b>Email:</b>
<b>Emergency Contact Name:</b>		<b>Phone:</b>
<b>Date of Birth:</b>	<b>Age:</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>CHIEF CONCERN</b>
What is the nature of your acute condition? Since when?
What medications &/or supplements are you taking for this problem?
Are you receiving any other treatment for this problem? If so, what and by whom?
What do you feel was the cause of this problem?

### SENSATION/FEELING:

Describe how this acute condition feels? (For examples reverse): \_\_\_\_\_

Are there any other sensations that occur with your acute condition? (For examples see reverse): \_\_\_\_\_

What is the intensity of your condition? (Please circle)

Very Mild 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Extremely intense  
Moderate

### TIME:

How frequently do you experience the effects of this problem? (Please circle one or more)

- a) Constantly    b) Hourly    c) Daily    d) Nightly
- h) Other: \_\_\_\_\_

**MODALITIES:**

Indicate with a **W** any of the following that make your condition **WORSE**

Indicate with a **B** any of the following that make your condition **BETTER**

TEMPERATURE	ENVIRONMENT	MOTIONS	BODY FUNCTIONS
<b>Heat</b>	Damp	Commencing motion	Eating
Heat in general	Humid	Continued motion	Drinking
Heat of the sun	Windy	Exertion	Urinating
Warmth of a bed	Weather Changes	Rising Up	Defecating
Warm rooms	Overcast/Stormy	Resting	Sleeping
Application of heat	At an altitude	Stretching	Coughing
Warm water	Indoors	Lifting	Yawning
<b>Cold</b>	Outdoors	<b>POSITION</b>	Sneezing
Cold in general	By the sea	Lying	Sexual Activity
Cold air/draft	Other	Standing	Other
Cold water	<b>SENSORY</b>	Sitting	<b>PHSYCOLOGICAL</b>
Cold application	Touch	Stooping	Excitement
	Pressure	Stretched out	Effects of Anger
	Noise	Doubled up	Fear or shock
	Music	Right side	Stress
	Light	Left side	Worry
	Darkness	Stiff	Thinking about it
	Odors	Limp	While busy

**ASSOCIATED SYMPTOMS:**

Do you experience any other symptoms at the same time as this pain? (ex. diarrhea, perspiration, nausea):

\_\_\_\_\_

How do you feel mentally/emotionally with this problem? \_\_\_\_\_

\_\_\_\_\_

### TYPES OF PAIN

**Localization**  
Small spots  
Diffuse  
Spreading  
Changing

**Sore**  
Aching  
"Bruised"  
Dull ache

**Throbbing**  
Pulsating

**Tender**  
Sensitive

**Sharp**  
Stabbing  
Cutting  
Stitching  
Piercing  
Pricking  
Splinter-like  
Stinging

**Changeable**  
Wandering  
Shifting  
Erratic

**Shooting**  
Radiating  
Lancinating  
Boring  
Digging  
Twisting  
Drawing  
Pulling

**Spasmodic**  
Cramping  
Grabbing  
Jerking

**Burning**  
Cold needles  
Hot needles

**Stiff**  
Contracted  
Constricted  
Band-like

**Pressing**  
Compressive  
Crushing  
Squeezing  
Pinching  
Gnawing  
Tearing

**Lame**  
as if Dislocated  
as if Broken  
as if Sprained  
Paralytic pain

**Timing**  
Constant  
Recurrent  
Episodic  
Paroxysmal  
Remittent

**Examples of types of Pain & Sensations**

### TYPES OF SENSATIONS

**Frequency of Symptom**  
Constant  
Recurrent  
Episodic  
Paroxysmal  
Remittent

**Spasm**  
Tension  
Cramps

**Paresthesias**  
Tingling  
Formication  
Crawling  
Prickling

**Temperature**  
Coldness of area  
Chills  
Heat or warmth  
Burning sensation

**Numbness**  
Heaviness  
Pressure

**Tremors**  
Trembling  
Twitching  
Shaking  
Jerking

**Stiffness**  
Contracted  
Constricted  
Band-like

**Discoloration**

**Swelling**

**Deformity**  
Nodosities  
Osteophytes  
Contractures

**Weakness**  
Pain "as if paralyzed"  
Lame  
Awkward  
Uncoordinated

**Restlessness**  
to remove stiffness  
to relieve pain  
from nervous agitation

**Atrophy**  
Emaciation

**TYPES OF PAIN**