K-W HOMEOPATHIC MEDICINE AND WELLNESS CLINIC

NEW PATIENT INFORMATION

*All information provided is kept in strict confidence

Date: _____ **ACUTE PATIENT**

Name:		
Address:		
City:	**Province:**	**Postal Code:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Weight:	**Height:**	**Email:**
Emergency Contact Name:		**Phone:**
Date of Birth:	**Age:**	**Sex: ☐ Male ☐ Female**

CHIEF CONCERN
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: _____

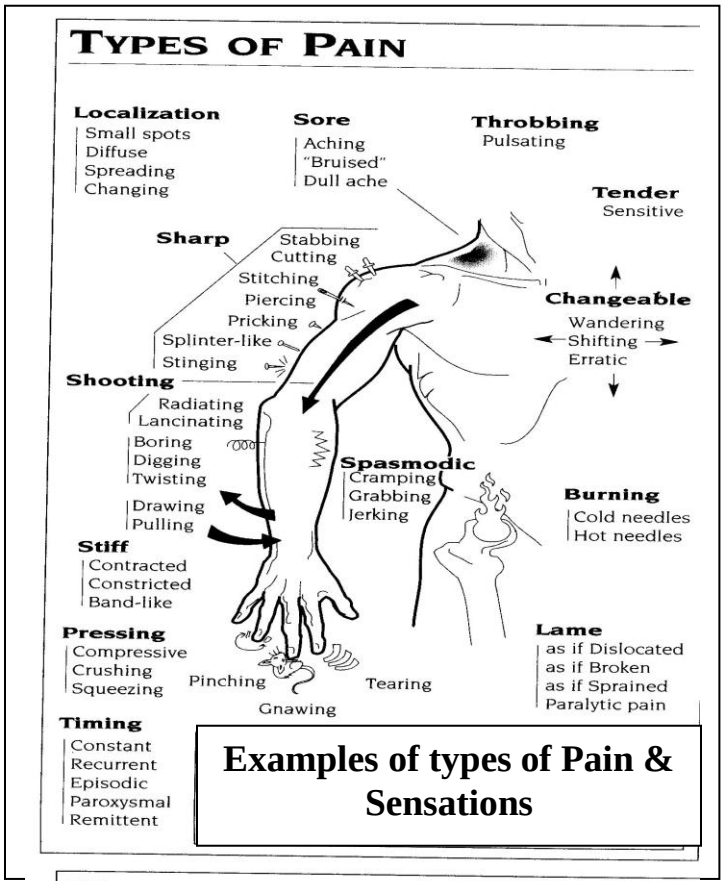
MODALITIES:
Indicate with a **W** any of the following that make your condition **WORSE**
Indicate with a **B** any of the following that make your condition **BETTER**

TEMPERATURE		ENVIRONMENT		MOTIONS		BODY FUNCTIONS	
Heat		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	
Cold		Outdoors		**POSITION**		Sneezing	
Cold in general		By the sea		Lying		Sexual Activity	
Cold air/draft		Other		Standing		Other	
Cold water		**SENSORY**		Sitting		**PHSYCOLOGICAL**	
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? _____
_____
_____



Examples of types of Pain & Sensations