Date ___________________________

Health History Summary

Name ____ Age __________ Date of Birth (y/m/d) ________________

Address: _________________________City:_____________Postal Code:__________ Phone: ________________(H) __________________(W)

E-mail (Correspondence and Newsletters): ____

☐ Please check this box if you DO NOT want to receive e-mails for newsletters and events.

In case of emergency contact __________________________________ Phone: ________________ (1) _____________________(2)

How did you hear about our clinic? ____

Your Current Health Concerns

What is your main reason for coming in today? ____

____

List, in order of importance other health problems that are troubling you:

1) ____ How long? ____________________
2) ____ How long? ____________________
3) ____ How long? ____________________
4) ____ How long? ____________________
5) ____ How long? ____________________

What kind of conventional treatment have you received? ____

____

Please circle all of the following complementary healthcare practitioners you have seen:

Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other ________________

What was the therapy and what were the results? ____

____

Last Physician or Health Practitioner seen ____ When ____________________

When was your last physical exam? ____________________________ Were blood tests done? **Y/N** Blood Type _____________

Your Health History

What is the general state of your health? **Excellent Good Average Fair Poor**

What is your current level of energy from 1-10 (where 10 is the best you've ever felt)? ___________

What is your current approximate weight? __________ One year ago? ___________ Ideal weight? __________ Height? _________

Please list the 5 most significant stressful events in your life:

1) ____ Date ____________________
2) ____ Date ____________________
3) ____ Date ____________________
4) ____ Date ____________________
5) ____ Date ____________________

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420 Main St. Unit 102-103
Milton, ON 905.878.8131

Patient Name: ______________________________
Date:___/___/_____

Are any of these situations continuing to impact your life? **Y/N** (*if yes, please circle which one*)

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? **Y/N**

Have you in the past? **Y/N**

Do you have any allergies to any drugs, herbs, foods, animals or other? **Y/N** *If yes, please specify* ____________________________

____

Have you had any major injuries? **Y/N** *If yes, what happened and when?* ____

____

Previous surgeries and hospitalizations (include dates) ____

____

Please indicate which of the following conditions you have had and indicate "now" (N) or "past" (P)

	N	P		N	P		N	P		N	P
Allergies			Weight Problems			Anemia			Measles		
Asthma			Gallstones			High Blood Pressure			Mumps		
Hayfever			Gout			Stroke			Chicken Pox		
Sinusitis			Thyroid Problems			Cancer			Whooping Cough		
Ear Infections			Speech Problems			Jaundice			Shingles		
Strep Throat			Tooth/Gum Problems			Alcoholism			Diphtheria		
Tonsillitis			Ringing in Ears			Hepatitis			Scarlet Fever		
Mono			Visual Problems			Gas/Bloating			Polio		
Eczema			Fainting			Diarrhea			Rheumatic Fever		
Psoriasis			Poor Memory			Constipation			Small Pox		
Acne			Balance Problems			Hemorrhoids			Malaria		
Warts			Broken Bones			Rectal Bleeding			Pneumonia		
Varicose Veins			Numbness/Tingling			Parasite			Tuberculosis		
Canker Sores			Cold Hands/Feet			Herpes			Child Abuse		
Headaches			Arthritis			STD			Physical Abuse		
Migraines			Epilepsy			Gonorrhea			Sexual Abuse		
Depression			Diabetes			Syphilis			Emotional Abuse		
Miscarriage			Heart Disease			HIV/AIDS			Rape		

Other? ____

Are there any ailments from which you feel you have never been well since? ____

Were you vaccinated? **Y/N** Did you have any adverse reactions (ex: fever)? **Y/N**

Which of the following do you currently use? (Please indicate how much, how often and how long.)

Alcohol __________________________ Tobacco __________________________

Hormones __________________________ Coffee __________________________

Cortisone __________________________ Tea __________________________

Sedatives __________________________ Laxatives __________________________

Antacids __________________________ Recreational Drugs __________________________

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Date:___/___/_____

Other Medications? (Please give name, dose, and amount of time on the medication.)

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Vitamins/Herbs?

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Family History

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other ____________				

General Information

Marital Status? **Single** **Married** **Divorced** **Separated** **Widow** **Other** ___________ Number of Children __________

Who do you currently live with? **Spouse** **Partner** **Parents** **Children** **Friends** **Alone**

Are you currently in a happy and supportive relationship? **Very** **Mostly** **Somewhat** **No**

What is your weakest organ system and why? (ex: digestive, immune, etc) ____

____

Do you exercise? **Y/N** *If yes, what do you do and how often?* ____

Occupation ____ Employer ____________________________________

Do you enjoy your work? **Y/N** Do you take vacations? **Y/N**

How often do you get colds, flus, and sore throats in a year? _______________

<u>Occupational/Household</u>

Is your home damp or moldy at all? **Y/N**

Do you have specialized air filtration at home? **Y/N**

Do you work in an office building? **Y/N**

Do the windows open? **Y/N**

Do you work in the presence of toxic fumes or chemicals? **Y/N**

Do your hobbies involved toxic materials? **Y/N**

Are you currently exposed to second hand smoke? **Y/N**

What do you use for drinking water? *(circle all that apply)* **Tap Water** **Bottled Water** **Filtered Water** **Reverse Osmosis**

Is there anything else you feel I should know about you? ____

____

Thank you for taking the time to fill out this lengthy questionnaire. It will be a valuable resource in understanding your health.

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Patient Name: ____________________________
Date:___/___/_____

Diagnosis and Treatment Consent Form

I, the undersigned, do hereby give my voluntary consent for the administration of acupuncture, dry needling acupuncture techniques and other relevant Chinese medical therapies.

Acupuncture and the dry needling technique have been explained to me as a traditional Chinese medical treatment performed by the insertion of special sterilized fine needles with or without the application of electrical stimulation through the skin into the underlying tissues and muscles at specific points on the body for the purpose of alleviating pain and treating other clinical conditions.

Ancillary techniques of acupuncture may include one or more of the following:

- Moxibustion -whereby herbal heat is applied to specific acupuncture points
- Cupping- whereby suction cups are applied to specific points on the body or motion suction cups
- Auricular Acupuncture- whereby needles, press tacks, or ears seeds are inserted onto the surface of the ear in order to effect healing.

I have been made aware of the possibility of complications which may result from these procedures. These include infection (rare), bruising and bleeding into the tissues, pain and discomfort, weakness, tiredness, fainting, nausea, aggravation of existing symptoms for a short time, etc.

I state that I do not have the following conditions:

• Pregnancy
• Bleeding disorders
• Pacemaker
• Local infections
• Taking Anticoagulants (blood thinners)

If I have any of the above conditions, I have listed them here: ---

----

I hereby certify that I have understood the above authorization and the risks involved. All relevant questions which I have asked have been answered.

Patient Name: (print) ---------------------------

Witness Name (print) ----------------------------

Patient Signature --------------------------------

Witness Signature --------------------------------

Date --

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