

Patient Health Summary – TCM Acupuncture

Grimsby Massage Therapy Clinic
3 Ontario Street
Grimsby, ON L3M 3G8
(905) 309-8694

Patient Information			
First Name:	Last Name:	Middle Name:	
Telephone (Home/Mobile):	Telephone (Business):	Sex: M / F / Other	
Home/Street Address:		Apt #:	Date of Birth: (MM/DD/YY)
City:		Province:	Postal Code:
Occupation:		Email:	
Family Contact Information		First name:	Last name:
Relationship to Patient:	Phone Number:	Mobile Number:	
Emergency Contact information (If different individual from above)	First name:	Last Name:	
Relationship to Patient:	Phone Number:	Mobile Number:	
Family Doctor Name:			
Clinic Address and Phone Number:			
Chief Complaint:			
<p style="text-align: center;"><i>Please describe the main health problem/condition you are seeking treatment for, the onset and duration and any concurrent treatments or therapies.</i></p>			
Past and Present Medical Conditions:			
<p style="text-align: center;"><i>Please check off any past and present health conditions and include dates below.</i></p>			
<input type="checkbox"/> Allergies/Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Digestive Disorder	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Other:
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> HIV Positive/AIDS	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> CFS/Fibromyalgia	<input type="checkbox"/> Heart Disease / Stroke	<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Depression	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Skin Conditions	
<p><i>Please list any injuries and surgeries you have experienced and include dates:</i></p>			

Please circle any conditions you are experiencing:

<p>General Symptoms</p> <p>Fatigue Poor or shallow sleep Body heaviness Body feels colder (chills) Body feels warmer (fever) Poor circulation Prefer cold drinks Prefer warm drinks Cold hands Cold feet Water retention or swelling Recent weight gain or loss Sweat easily</p>	<p>HT Symptoms</p> <p>Insomnia Dream-disturbed sleep/nightmares Anxiety Palpitations Chest pains Speech problems Restlessness Hyperactivity Overly talkative Inability to concentrate Poor memory Startled easily Faint easily Waking up in middle of the night</p>	<p>LU Symptoms</p> <p>Cough Wheezing Frequent colds Shortness of breath Difficulty breathing Chest tightness Nose and throat problems:</p> <p>Repeated sore throat Swollen glands Sadness or grief Cry easily Foggy or clouded mind Skin problems:</p>
<p>LR Symptoms</p> <p>Depression Moody Irritability Indecisiveness Sighing Nervousness Distension pain in the chest or ribs Feeling of lump in throat Numbness of the limbs Eye/vision problems:</p> <p>Emotionally triggered symptoms: Headache, poor digestion, insomnia, etc.</p> <p>Repressed emotions Easily angered Dizziness or vertigo Trembling or shaky hands Tics or twitching Muscle cramp or spasm Tight and stiff muscles Severe migraines and headaches</p>	<p>KI Symptoms</p> <p>Sore/weak lower back Sore/weak knee joint Low sex drive Overwork or intensive workouts Night sweat Teeth or hair loss Ear problems:</p> <p>Exhaustion Afternoon crash Fears Addictive patterns Abuse survivor Lack of motivation or drive Forgetfulness Urinary problems:</p>	<p>SP/ST Symptoms</p> <p>Poor appetite Improper eating habits Bloating or gas Abdominal distension and pain Loose stools Diarrhea Constipation Rectal problems Hemorrhoids Muscle weakness Bleed or bruise easily Excessive worrying Obsessive thoughts Nausea Vomiting Acid reflux Bad breath Mouth/gum problems Cravings:</p>
	<p>Gynecology</p> <p>Abnormal vaginal discharge/odor/color Breast lumps Irregular menstruation Amenorrhea (absence of menstruation) Dysmenorrhea (painful menstruation) Excessive menstrual bleeding Ovarian cysts Endometriosis Birth Control Menopausal symptoms:</p>	<p><i>Currently Pregnant</i></p> <p># of weeks pregnant: _____ # of past pregnancies: _____ # of live births: _____ Delivery due date: _____</p> <p><i>Menstrual Cycle</i></p> <p>Date of last period: _____ Days in cycle: _____ Length of period: _____ Menstrual flow, color, clots:</p> <p>Premenstrual Symptoms:</p>

Current Medication, Supplement or Herbs (indicate the condition that it treats):

Please list any allergies and drug reactions:

Family Health History (including dates):

Father:

Mother:

Siblings:

Other (grandparents, aunts, uncles):

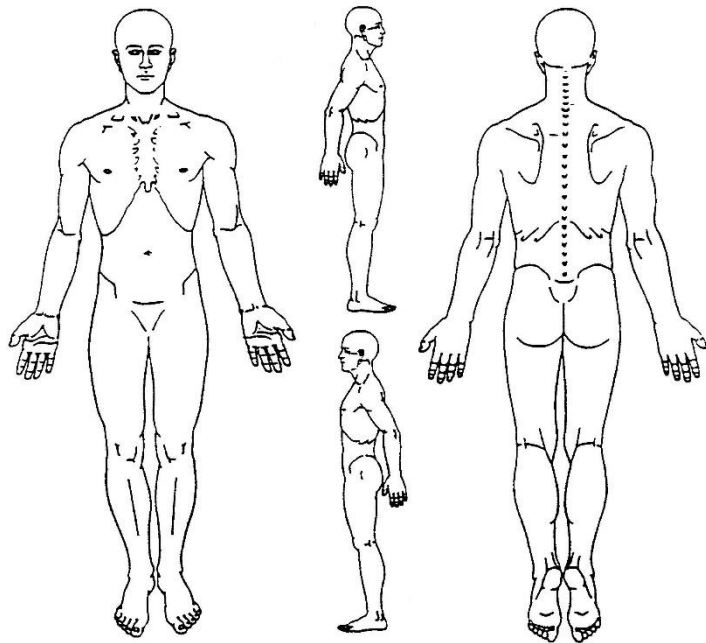
Pain Chart

Please mark the area of pain or discomfort with the appropriate letter.

- | | |
|------------------|---|
| Ache/throbbing | X |
| Dull pain | D |
| Sharp/stabbing | S |
| Burning | B |
| Tightness | T |
| Numbness | N |
| Pins and needles | P |

Pain Scale:

On a scale of 1 to 10, please indicate how bad is the pain.
10 = severe



Signature of Patient:

Date:

Or Substitute Decision Maker:

Practitioner: