BRAMPTON ACUPUNCTURE

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name: ______________________________

Street: ____________ City ____________ Prov ________ P.C. ________

Age: ____________ Height: ____________ Weight ____________

Home Phone: ____________ Work Phone: ____________

Cell: ____________ Email: ____________

Date/Place of Birth: ____________

Occupation: ____________ Marital Status: ____________

In Emergency Notify: ____________

How did you hear about our clinic? ____________

Family Physician: ____________

Insurance Carrier: ____________

Have you tried acupuncture or Chinese herbal medicine before? ____________

Main problem(s) you would like to address: ____________

____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? ____________

____

How long has it been since you first noticed any symptoms? ____________

Have you been given a diagnosis for the problem by your family physician? ____________

If so, what is it? ____________

What kinds of treatment have you tried? ____________

Past medical history (please include dates):

- ☐ Allergies: ________
- ☐ Diabetes ________
- ☐ High Blood Pressure ________
- ☐ Seizures ________
- ☐ Surgeries ________
- ☐ Thyroid Disease: ________
- ☐ Cancer ________
- ☐ Hepatitis ________
- ☐ Heart disease ________
- ☐ Rheumatic Fever ________
- ☐ Venereal Disease ________
- ☐ Other significant illness (describe): ____________
- ☐ Accidents or Significant Trauma (describe) ____________

Birth History (prolonged labor, forceps delivery, etc): ____________

Other relevant medical history: ____________

____

____

____

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Family Medical History:

- ☐ Allergies ______
- ☐ Cancer ______
- ☐ Seizures ______
- ☐ Diabetes ______
- ☐ Heart Disease ______
- ☐ Stroke ______
- ☐ Asthma ______
- ☐ High Blood Pressure
- ☐ Other ______

Occupation: ______

Occupational stress factors (physical, psychological, chemical): ______

______

Lifestyle:

Do you follow a regular exercise program? ______ If so, please describe: ______

______

Please describe your average daily diet: ______

______

Please check any of the following habits that apply. Indicate how much and how often you consume them: ______

☐ Cigarette smoking ______ ☐ Coffee, tea or cola ______ ☐ Alcoholic beverages ______

______

Medications taken within the last two months (vitamins, drugs, herbs, etc.): ______

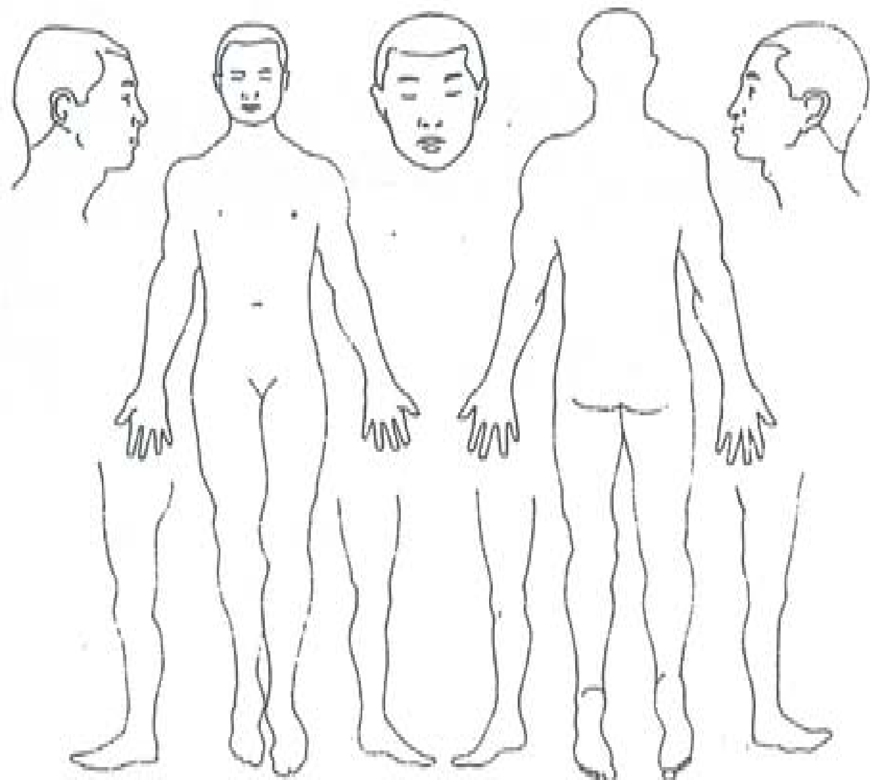
______

Please describe any use of drugs for non-medical purposes: ______

______

Indicate painful or distressed areas

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
≈	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
−	colder
+	hotter
Physical	
⊗	sores
∇	rashes
⇒⇐	spasms



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Please put a check next to conditions you have experienced within the last three months. Indicate the length of time you have had this condition:

General:

- ☐ Poor appetite ________
- ☐ Insomnia ________
- ☐ Disturbed sleep ________
- ☐ Localized weakness ______
- ☐ Cravings ________
- ☐ Strong thirst ______
- ☐ Weight gain ________
- ☐ Weight loss ______
- ☐ Changes in appetite________
- ☐ Sweating easily________
- ☐ Tremors________
- ☐ Bleeding or bruising easily ______
- ☐ Night Sweats ________
- ☐ Fever ________
- ☐ Chills________
- ☐ Sudden energy drop (time of day?) ________
- ☐ Poor balance ________
- ☐ Other unusual or abnormal conditions you have noticed in your general sense of health?

____

Skin and hair

- ☐ Rashes ________
- ☐ Ulcerations________
- ☐ Hives ________
- ☐ Itching________
- ☐ Eczema________
- ☐ Pimples ________
- ☐ Dandruff________
- ☐ Hair loss________
- ☐ Recent moles ________
- ☐ Changes in hair or skin texture________

Any other hair or skin problems?____

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness ________
- ☐ Concussions ________
- ☐ Migraines________
- ☐ Glasses ________
- ☐ Spots in front of eyes ______
- ☐ Eye pain________
- ☐ Poor vision ________
- ☐ Night blindness ________
- ☐ Color blindness ______
- ☐ Cataracts ________
- ☐ Blurry vision ________
- ☐ Earaches ________
- ☐ Ringing in ears ______
- ☐ Poor hearing ______
- ☐ Eyestrain ________
- ☐ Sinus problems ______
- ☐ Recurrent sore throats ______
- ☐ Nose bleeds ________
- ☐ Grinding teeth ______
- ☐ Sores on lips or tongue ______
- ☐ Facial pain ________
- ☐ Teeth problems ______
- ☐ Headaches (where? when?) ____
- ☐ Jaw clicks ________

Any other head or neck problems? ____

Cardiovascular

- ☐ Dizziness ________
- ☐ Low blood pressure ________
- ☐ Chest pain ________
- ☐ Irregular heartbeat ____
- ☐ High blood pressure ________
- ☐ Fainting ________
- ☐ Cold hands or feet ____
- ☐ Swelling of hands ________
- ☐ Swelling of feet ______
- ☐ Blood clots ________
- ☐ Difficulty in breathing ________
- ☐ Phlebitis ________

Any other heart or blood vessel problems?____

Respiratory

- ☐ Cough ______
- ☐ Coughing up blood ______
- ☐ Asthma ______
- ☐ Bronchitis ______
- ☐ Pain with deep inhalation ______
- ☐ Pneumonia ______
- ☐ Difficulty breathing when lying down ______
- ☐ Production of phlegm (color?) ______

Any other lung problems? ____

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Gastrointestinal

☐ Nausea ______ ☐ Vomiting ______ ☐ Diarrhea ______
☐ Constipation ______ ☐ Gas ______ ☐ Belching ______
☐ Black stools ______ ☐ Blood in stools ______ ☐ Indigestion ______
☐ Bad breath ______ ☐ Rectal pain ______ ☐ Hemorrhoids ______
☐ Abdominal pain or cramps ______ ☐ Chronic laxative use ______
Any other problems with stomach or intestines? ____________________

Genito-Urinary

☐ Pain on urination ______ ☐ Frequent urination ______ ☐ Blood in urine ______
☐ Urgency to urinate ______ ☐ Unable to hold urine ______ ☐ Kidney stones ______
☐ Decrease in flow ______ ☐ Impotence ______ ☐ Sores on genitals ______
Do you wake up at night to urinate?__________If so, how often? ____________
Any particular color to your urine? ____________________
Any other problems with your genital or urinary functions? ____________________

Reproductive and Gynecologic

☐ Menstrual clots ______ ☐ Painful menses ______ ☐ Unusual menses (heavy or light?) ______
☐ Changes in body/psyche prior to menstruation ______
☐ Irregular menses ______ ☐ Menopause (age?____) ☐ Other problems ______
Age at first menses ______ Length of time between menses ______ Duration ______
First day of last menses ______Number of pregnancies ______ Premature births ______
Miscarriages ______ Abortions ______ Number of births ______
Do you practice birth control? ______ If so, what type? ______ For how long? ______

Musculoskeletal

☐ Neck pain ______ ☐ Muscle pains ______ ☐ Knee pain ______
☐ Back pain ______ ☐ Muscle weakness ______ ☐ Foot/ankle pains ______
☐ Hand/wrist pains ______ ☐ Shoulder pains ______ ☐ Hip pain ______
Any other joint or bone problems? ____________________

Neuropsychological

☐ Seizures ______ ☐ Dizziness ______ ☐ Loss of balance ______
☐ Areas of numbness ______ ☐ Poor memory ______ ☐ Lack of coordination ______
☐ Concussion ______ ☐ Depression ______ ☐ Anxiety ______
☐ Bad temper ______ ☐ Easily susceptible to stress ______
Have you ever been treated for emotional problems?____________________
Have you ever considered or attempted suicide? ____________________
Any other neurological or psychological problems? ____________________

Comments

Please tell us of any other problems you would like to discuss: ____________________
____

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HEALTH AND TREATMENT CONSENT FORM
FOR BRAMPTON REGISTERED MASSAGE THERAPY &/OR BRAMPTON ACUPUNCTURE

Note to Patient: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain from you. If you have a question on any of this, please ask.

CONSENT TO TREATMENT FORM

I, ______________________________ of my own free will consent to be treated for the following complaint(s):

____

____

I acknowledge that my Massage Therapist &/or Acupuncturist, Chiropractor, Osteopath has provided me with such information as is pertinent for treatment of the above listed complaint(s).
Alternative courses of treatment where applicable and relevant have been explained to me as well as the possible risks and side effects of my therapist's proposed treatment plan.
I understand fully the consequences of having treatment/not having treatment.
I appreciate that my consent herein provided, may be revoked at any time if I so choose.

In compliance with the "consent to Treatment Act" 1992, I provide my full Voluntary Informed consent to be treated by Linda Baird B.A., R.M.T. or Andy Baird B.A., D.Ac. or any one of the clinics associates'.

CONSENT FOR THE COST OF SERVICES

The therapist will review the costs of treatment effective today ______________________________.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Massage Therapy &/or Acupuncture, Chiropractic, Osteopathic services, Brampton Registered Massage Therapy Clinic &/or Brampton Acupuncture & Herbal Medicine Clinic will collect some personal information about me (e.g. Telephone numbers to contact you, address health issues on our Health History form).

I have reviewed the Brampton Registered Massage Therapy Clinic and Brampton Acupuncture & Herbal Medicine Clinic's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand that only if I check off the following spaces I will NOT receive any of the following:

____ I, **do not** want to receive notice when it is time to review whether I need new services.
____ I, **do not** want to receive notice of New modalities offered or changes withing the clinic e.g. New R.M.T's
____ I, **do not** want to receive newsletters and other informational mailings and notice of promotions or cards such as birthday, sympathy or general cards of caring.
____ I, **do not** want to receive a Thank you call for referring someone to the clinic.
____ I, **do not** give the clinic permission to call to thank the patient that referred me to the clinic (if applicable).
____ I, **do not** want a report &/or progress report sent to my referring Doctor (if applicable), this may contain information such as; what I presented with, type of treatment received, outcome of treatment, homecare assigned and a recommended treatment plan. A progress report may contain the above with added information on your progress.
____ I **do not** want (list what you would like to add) ______________________________

I understand that, as explained in the Policies and Procedures for personal information, there are some rare exceptions to these commitments.

I agree to Brampton Registered Massage Therapy Clinic &/or Brampton Acupuncture & Herbal Medicine Clinic using and disclosing personal information about me as set out above and in the Brampton Registered Massage Therapy Clinic &/or Brampton Acupuncture & Herbal Medicine Clinic's Privacy Policy.

SIGNATURE: ______________________ PRINTED NAME: ______________________

WITNESS: ______________________ DATE: ______________________

ADDITIONAL NOTES MADE BY THE PATIENT&/OR BRAMPTON REGISTERED MASSAGE THERAPY CLINIC &/OR BRAMPTON ACUPUNCTURE & HERBAL MEDICINE CLINIC. ______________________

____

____