

Health History Form

First Name:	Last Name:	Date:
Address:		Email:
Home #:	Work #:	Cell #:
Date of Birth:	Gender:	Occupation:
Emergency Contact:		Contact #:

Chief Complaint and Duration:

(Please identify the main health problem/condition and how long you have experienced this for)

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Past and Present Medical Conditions: (Please include dates)

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Allergies/Asthma
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer
<input type="checkbox"/> CFS/Fibromyalgia
<input type="checkbox"/> Depression/Mental Condition
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestive Disorder
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Heart Disease/Stroke
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis/Liver Disease
<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Other: |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please list any injuries and surgeries you have experienced with dates:

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

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Family Health History: (Please include dates)

Father:

Mother:

Other:

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Lifestyle

Work hours per week: _____ Sleep hours per night: _____

Special diet and food sensitivity: _____

Exercise type and frequency: _____

Caffeine/Smoke/Alcohol/Substance use and frequency: _____

Energy and Stress Levels: (Please circle)

Energy levels: High Average Low Extremely Low

Stress levels: Low Average High Extremely High

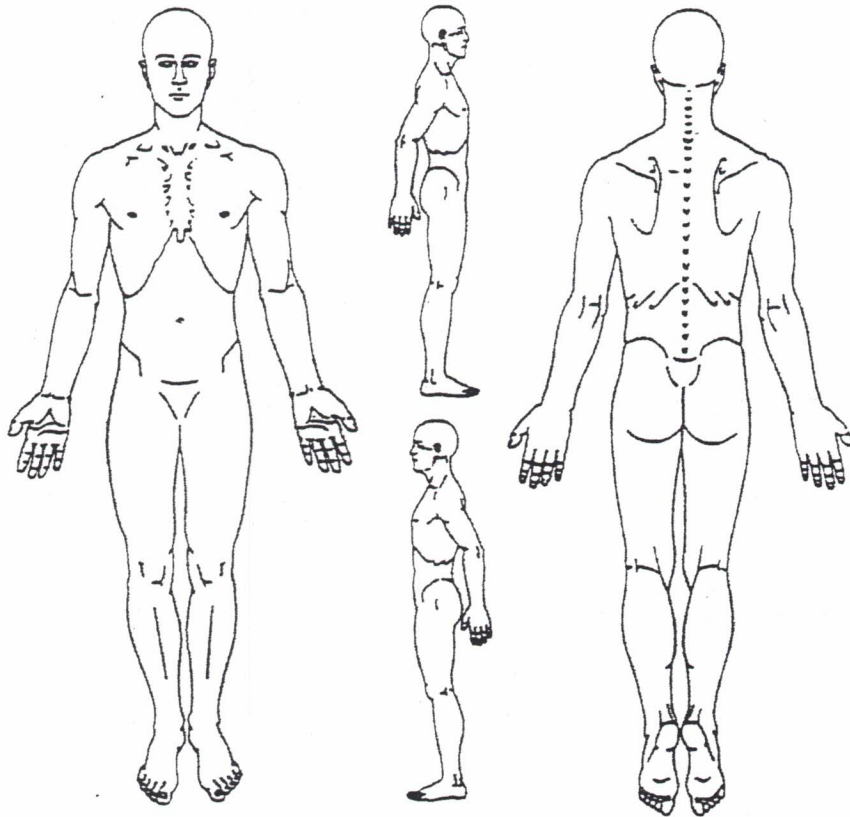
If energy or stress levels are extremely low or high, please explain: _____

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 & needles | P |

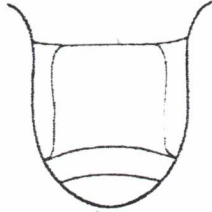
Pain Scale: On a scale of 1 to 10 (10 = severe) how bad is the pain?



<u>General Symptoms</u>	
<input type="checkbox"/> Fatigue <input type="checkbox"/> Poor or shallow sleep <input type="checkbox"/> Body heaviness <input type="checkbox"/> Body feels more cold (chills) <input type="checkbox"/> Body feels more warm (fever) <input type="checkbox"/> Poor circulation	<input type="checkbox"/> Prefer cold drinks <input type="checkbox"/> Prefer warm drinks <input type="checkbox"/> Cold hands <input type="checkbox"/> Cold feet <input type="checkbox"/> Water retention or swelling <input type="checkbox"/> Recent weight gain or loss <input type="checkbox"/> Sweat easily
<u>Heart Symptoms</u>	
<input type="checkbox"/> Insomnia <input type="checkbox"/> Dream-disturbed sleep <input type="checkbox"/> Anxiety <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pains <input type="checkbox"/> <u>Speech problem:</u>	<input type="checkbox"/> Restlessness <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Being overly talkative <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Startled easily <input type="checkbox"/> Faint easily
<u>Liver Symptoms</u>	
<input type="checkbox"/> Depression <input type="checkbox"/> Moody <input type="checkbox"/> Irritability <input type="checkbox"/> Indecisive <input type="checkbox"/> Sighing <input type="checkbox"/> Nervousness <input type="checkbox"/> Distension pain in the chest or ribs <input type="checkbox"/> Feeling of lump in the throat <input type="checkbox"/> Numbness of the limbs <input type="checkbox"/> <u>Eye problem:</u>	<input type="checkbox"/> Emotional triggered symptom (eg. headache, poor digestion, insomnia) <input type="checkbox"/> Repressed emotions <input type="checkbox"/> Easily angered <input type="checkbox"/> Dizziness or vertigo <input type="checkbox"/> Trembling or shaky hands <input type="checkbox"/> Tics or twitching <input type="checkbox"/> Muscle cramp or spasm <input type="checkbox"/> Tight and stiff muscles <input type="checkbox"/> Severe migraines and headaches
<u>Spleen/Stomach Symptoms</u>	
<input type="checkbox"/> Improper eating habits <input type="checkbox"/> Poor appetite <input type="checkbox"/> Bloating and gas <input type="checkbox"/> Belching and hiccup <input type="checkbox"/> Abdominal distension and pain <input type="checkbox"/> Loose stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> <u>Rectal problem:</u>	<input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Worry a lot <input type="checkbox"/> Obsessive thoughts <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Acid reflux <input type="checkbox"/> Bad breath <input type="checkbox"/> <u>Mouth/gum problem:</u> <input type="checkbox"/> <u>Cravings:</u>

<u>Lung Symptoms</u>		
<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Chest tightness <input type="checkbox"/> <u>Nose and throat problem:</u>	<input type="checkbox"/> Repeated sore throat <input type="checkbox"/> Swollen glands <input type="checkbox"/> Sadness or grief <input type="checkbox"/> Cry easily <input type="checkbox"/> Foggy or clouded mind <input type="checkbox"/> <u>Skin problem:</u>	
<u>Kidney Symptoms</u>		
<input type="checkbox"/> Sore/weak lower back <input type="checkbox"/> Sore/weak knee joint <input type="checkbox"/> Low sex drive <input type="checkbox"/> Overwork or intensive workout <input type="checkbox"/> Night sweat <input type="checkbox"/> Teeth or hair loss <input type="checkbox"/> <u>Ear problem:</u>	<input type="checkbox"/> Exhaustion or afternoon crash <input type="checkbox"/> Fears <input type="checkbox"/> Addictive patterns <input type="checkbox"/> Abuse survivor <input type="checkbox"/> Lack motivation or drive <input type="checkbox"/> Forgetfulness <input type="checkbox"/> <u>Urination problem:</u>	
<u>Gynecology</u>		
<input type="checkbox"/> Menopausal <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Breast lumps <input type="checkbox"/> Currently pregnant # of weeks pregnant: # of past pregnancies: # of live births: Delivery due date:	<input type="checkbox"/> Irregular menstruation <input type="checkbox"/> Severe menstrual cramps Date of last period: Days in cycle: Length of period: Menstrual flow, colour, clots: Premenstrual Symptoms:	

----- INTAKE ENDS HERE -----

<u>Observation, Listening, Smelling and Palpation</u>			
Vitality: (Spirit, face, hair, nails, skin, body shape, voice, smell)			
Tongue: (body shape, colour, movement, coating thickness, colour, moisture, location, and sublingual veins)			
Pulse: (rate, strength, quality)			
	Kidney Yang	Kidney Yin	
	Spleen	Liver	
	Lung	Heart	

<u>TCM Disease Diagnosis:</u>		
TCM Syndrome Differentiation	Treatment Principles	Acupuncture Prescription (Indicate additional modalities)
Primary Diagnosis:		
Secondary Diagnosis:		
		# of needles in: # of needles out:

Treatment Results, Treatment Plan and Recommendations: (# and frequency of Tx)

Patient Informed Consent to Treatment

Milena Nikolic #3947/ Holly Chiropractic

2 Marsellus Dr #15, Barrie

705 728-9999

I _____ consent to have Milena Nikolic PT, R.Ac perform the following treatment on me:

- Acupuncture
- Cupping

I acknowledge that Milena Nikolic PT, R.Ac has explained the following to me:

- the nature of the treatment [set out above]
- the expected benefits of the treatment [*the Practitioner may list them on the form*]
- the material risks of the treatment [*the Practitioner may list them on the form*]
- the material side effects of the treatment [*the Practitioner may list them on the form*]
- alternatives to having the treatment [*the Practitioner may list them on the form*]
- the likely consequences of not having the treatment [*the Practitioner may list them on the form*]

I acknowledge that my Traditional Chinese Medicine Practitioner or Acupuncturist cannot guarantee the results of the proposed treatment.

I acknowledge that I have informed my Traditional Chinese Medicine Practitioner or Acupuncturist about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.

I understand that I have the right to withdraw my consent to the treatment at any time.

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. I acknowledge that my Traditional Chinese Medicine Practitioner or Acupuncturist has explained the applicable fees to me.

I acknowledge that I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for the treatment or plan of treatment set out above.

Signature of Patient or Substitute Decision-Maker: _____ Date: _____

Practitioner's Signature: _____ Date: _____

By signing this form, I acknowledge that I have reviewed the form with the patient (or substitute decision-maker) and have answered the patient's (or substitute decision-maker's) questions.

Consent to Collect Use, and Disclose Personal Health Information

Milena Nikolic #3947/ Holly Chiropractic

2 Marsellus Dr #15, Barrie

705 728-9999

I _____, or my substitute decision-maker

Print name

Print name if applicable

Consent

Do not consent

For Holly Chiropractic and Wellness to collect, use and disclose my personal health information for the purpose of providing traditional Chinese medicine or acupuncture to me and for the related purposes set out in Holly Chiropractic and Wellness Written Privacy Statement.

The personal health information that may be collected, used or disclosed by the Clinic may include the following, among other things:

- my birth date and contact information
- my health history and family health history
- my health status
- the health care I receive (including identifying my health care provider(s));
- my health number
- the identification of my substitute decision-maker, if any
- insurance or billing information relating to health care

I understand that there may be situations in which practitioners at Holly Chiropractic and Wellness will have to collect, use or disclose personal health information without my consent, but that they will only do this if permitted by law.

How My Information Will Be Used

I understand that my personal health information may be collected, used or disclosed for the following reasons:

- To provide me with traditional Chinese medicine or acupuncture services
- To obtain payment for services provided
- To assist insurance companies with insurance claims verification
- To seek advice for potential treatment options
- To provide or arrange health care in cases of emergencies
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal health information is available to me for my review except in limited circumstances as permitted by law. I also understand that I can ask to have my personal health information corrected if I believe there is a mistake in the records, with some exceptions.

Acknowledgment

I allow Holly Chiropractic and Wellness to collect, use and disclose my personal health information as outlined above.

I understand that I can access my personal health information with some limited exceptions.

I understand that I am not required to sign this form and that I can withdraw my consent at any time by contacting Holly Chiropractic and Wellness, but it may directly affect the services I can receive. My personal health information may still be collected, used or disclosed if permitted by law.

Additional Comments or Restrictions:

Patient Signature:

Date:

Witness Signature:

Date: