Balanced Way

44 Palmer Rd., Grimsby, ON, L3M 5L5
905-317-8899

Health History Form

Christopher W C Cole, MA, R.AC, R.TCMP

First Name: _____

Last Name: _____

Address: _____

City: _____

Postal Code: _____ _____

Phone Number : home: ( )_____-_____

work: ( )_____-_____

cell: ( )_____-_____

Occupation:_____

Email: _____

Date of Birth: _ _ / _ _ / _ _ _ _ dd/mm/yyyy

Sex: M F Height: ___ft ___in Weight: ____lbs

Relationship Status: Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Number of children:_____

Emergency Contact: _____ Relationship: _____ Phone: ( )_____-_____

Where did you hear about the clinic? _____

Was this a Referral? Yes__ No__ Who Referred You:_____

Where did you grow up? Town:_____ Country:_____

Family Doctor: Name _____ Phone Number: ( )_____-_____

Please carefully read the following and sign below.

1. Welcome to Balanced Way and thank you for your interest in Acupuncture and Traditional Chinese Medicine.
2. Acupuncture and other TCM treatment modalities are safe and effective for the prevention and treatment of a wide variety of health problems and for the promotion of well-being. I will help you on your journey to wellness. Although TCM/Acupuncture are helpful for many health conditions, it is not intended to replace any tests or treatments recommended by your doctor. Please continue with your prescribed medications while you recieve treatments from this clinic
3. TCM/Acupuncture is NOT covered by OHIP. Coverage is provided by some extended healthcare plans. Please check your employee benefits.
4. Please note that Acupuncture and Tuina massage treatments are safe. Occasional bruising and post-needling sensation may happen. Fainting may occur for new patients due to nervousness, hunger or extreme tiredness. If you have any concerns, please do not hesitate to ask.

The clinic requires 24 hours notice when cancelling appointments.
Missed appointments (with no notice) : A fee of $50 will be due at the begining of the next appointment.
A $25 NSF fee will be applied to any returned cheques.

Exemption of Liability Clause:

I _____(undersigned patient) understand that any medical treatment (traditional Chinese or otherwise) involes some risks. I have discussed my symptoms with Christopher Cole, and Christopher has informed me of the risks involved in the treatment I will receive. I consent to receiving treatment after having been fully informed of the potential risks. I understand that my full and frank disclosure of my problems and symptoms and honest answers to the questions Christopher has asked me are crucial to his ability to provide me with accurate information and effective treatment. All disclosure will fall under the privacy law. I understand that some risks are involved and I voluntarily accept those risks. I have read and understood this form.

_____
Name of Patient (please print)

_____
Signature of Patient

Date: __ __ / __ __ / __ __ __ __ dd / mm / yyyy

Christopher W C Cole, MA, R.AC, R.TCMP
Practitioner

_____
Signature of Practitioner

Date: __ __ / __ __ / __ __ __ __ dd / mm / yyyy

Purpose of Visit (please circle)

Consultation Only | Consultation and Treatment | Acupuncture | Cosmetic Acupuncture | Tuina Massage

Your Lifestyle

1. What did you have yesterday/today for:

Breakfast: _____

Lunch: _____

Dinner: _____

Drinks:: _____

In between meals: _____

2. Do you have any of the following:

Cellular phone? Yes__ No__ Is it always on? Yes__ No__ When is it off:_____

Cordless telephones in home? Yes__ No__ How many? ____ In the bedroom? Yes__ No__

i-Pod? Yes__ No__ i-Pad? Yes__ No__ How many hours of use per day? _____

3. Number of televisions in the home? _____ Number of people in the home? _____ In the bedroom? Yes__ No__

Hours of TV watched **per day?** 0 - 1 hours? _____ 2 - 5 hours? _____ 6+ hours? _____

List programs you regularly watch: _____

List newspapers/magazines you regularly read: _____

4. Do you do any of the following:

Drink Alcohol?	Yes__ No__ (8oz glasses / 1 beer)	How many?	per day___	per week___	per month_____
Smoke?	Yes__ No__ (includes pipe tobacco)	Packs/Tobacco?	per day___	per week___	per month_____
Drink Caffeine?	Yes__ No__ (includes tea, cola, energy drinks)	How many?	per day___	per week___	per month_____
Exercise?	Yes__ No__	Times?	per day___	per week___	duration _____
Recreational drugs?	Yes__ No__	Times?	per day___	per week___	per month_____

5. Are you sexually active? Yes__ No__

Do you feel safe at home? Yes__ No__

Do you have at least one close friend? Yes__ No__

Do you have a religion / spiritual practice? Yes__ No__ Do you attend or practice regularly? Yes__ No__

Favorite Colour: _____

Favorite Season: _____

Leisure Activities: _____

Describe your employment: _____

History of the Present Desease, Illness or Symptom

1. Onset of the disease / illness:
2.Characteristics of the main symptoms:
3. Accompanying symptoms:
4. Relieving/exacerbating factors:
5. Tests/diagnosis:
6. Treatment as well as the results:

Check off any of the following conditions that you are experiencing or have experienced in the past year.

General Symptons

- ☐ poor appetite
- ☐ heavy appetite
- ☐ lack of strength
- ☐ bodily heaviness
- ☐ insomnia
- ☐ heavy sleep
- ☐ troubled sleep
- ☐ chills
- ☐ night sweats
- ☐ sweat easily
- ☐ cold hands / feet
- ☐ fever
- ☐ bleed or bruise easily
- ☐ recent weight change
  - gain ☐ loss ☐
  - number of pounds:_____

Head, Eyes, Ears, Mouth, Nose and Throat

- ☐ glasses
- ☐ eye strain
- ☐ eye pain
- ☐ red eyes
- ☐ itchy eyes
- ☐ poor vision
- ☐ blurred vision
- ☐ spots in the eyes
- ☐ cataracts
- ☐ glaucoma
- ☐ night blindness
- ☐ recurrent sore throat
- ☐ swollen glands
- ☐ lumps in throat
- ☐ enlarged thyroid
- ☐ teeth problems
- ☐ grinding teeth
- ☐ TMJ
- ☐ gum problems
- ☐ sores on lips / tongue
- ☐ dry mouth
- ☐ excessive saliva
- ☐ facial pain
- ☐ poor hearing
- ☐ concussions
- ☐ sinus problems
- ☐ nose bleeds frequency _____
- ☐ ringing in ears frequency _____
- ☐ headaches frequency _____
- ☐ migraines frequency _____
- ☐ earaches frequency _____
- ☐ toothaches frequency _____

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ poor circulation
- ☐ fainting
- ☐ blood clots
- ☐ phlebitis
- ☐ tachycardia
- ☐ irregular heartbeat
- ☐ heart palpitations
- ☐ heart disease specify:_____
- ☐ stroke specify:_____
- ☐ varicose veins [Dr. diagnosed?] Yes ☐ No ☐
- ☐ chest pain, frequency: _____

level of pain:____ (0=no pain, 10=unbearable pain)

Respiratory

- ☐ asthma
- ☐ shortness of breath
- ☐ difficulty breathing lying down
- ☐ pneumonia
- ☐ breathing problems

specify:_____

- ☐ cough- please circle below

wet / dry

- ☐ phlegm- please circle below

thick / thin

colour: _____

- ☐ excessive phlegm
- ☐ coughing blood

Musculoskeletal - pain/stiffness

- ☐ neck
- ☐ low back
- ☐ mid back
- ☐ shoulders
- ☐ joint pain
- ☐ limited use of joint
- ☐ limited range of motion
- ☐ other describe:_____
- ☐ rib pain
- ☐ leg: left / right
- ☐ knee: left / right

Skin and Hair

- ☐ acne
- ☐ psoriasis
- ☐ eczema
- ☐ rashes
- ☐ hives
- ☐ ulcerations
- ☐ skin tags
- ☐ itching
- ☐ hair loss
- ☐ fungal infections
- ☐ change in hair / skin texture
- ☐ dandruff
- ☐ brittle nails
- ☐ soft nails

Neuropsychological

- ☐ tics
- ☐ anxiety
- ☐ easily stressed
- ☐ depression
- ☐ seizures
- ☐ vertigo / dizziness
- ☐ PTSD
- ☐ irritabilty
- ☐ numbness
- ☐ poor memory
- ☐ abuse survivor
- ☐ considered / attempted suicide
- ☐ clumbsy

Are you seeing a councilor, therapist, social worker? Yes ☐ No ☐

if yes, please describe:

Gastrointestinal

- ☐ gas
- ☐ bad breath
- ☐ hiccuping
- ☐ bloating
- ☐ vomiting
- ☐ acid regurgitation
- ☐ nausea

frequency:_____

- ☐ diarrhea
- ☐ constipation
- ☐ laxative use
- ☐ intestinal pain / cramps
- ☐ hemorrhoids
- ☐ rectal pain
- ☐ anal fissures

anus: itching ☐ burning ☐

- ☐ kidney stones
- ☐ gall bladder stones

Bowel Movements

frequency of : less than 1 day_____ 2 days_____ 3 days_____

colour:_____ odor:_____ texture:_____ form_____

Stools: please circle any on the following- black / bloody / mucousy

Urinary

frequency: times per day_____ colour:_____ odor:_____

Urination: please circle any of the following that apply-
clear / cloudy / bloody / painful / urgent need / unable to hold / bedwetting / incomplete urination / waking to urinate / unknown leakage

For Women

Menstural Cycle

age mesa began:____

lenght of period: ____ days

lenght of cycle: ____ days

date last period began:
_ _ / _ _ / _ _ _ _
dd / mm / yyyy

- ☐ PMS
- ☐ irregular periods
- ☐ painful periods
- ☐ clots
- ☐ very heavy periods
- ☐ birth control pills

Vaginal

- ☐ vaginal sores
- ☐ yeast infection
- ☐ vaginal discharge

colour:_____ odor_____

- ☐ premature births

# of pregnancies ____

# of live births ____

Perimenopausal

age at onset: ____

- ☐ HRT pills

Postmenopausal

age at last period: ____

- ☐ urinary tract infection

frequency:_____

For Men

- ☐ impotence
- ☐ premature ejaculation
- ☐ nocturnal emission
- ☐ increased libido
- ☐ decreased libido
- ☐ urinary tract infection, frequency:_____

how often do you get together with male friends?_____

hobbies:_____

frequency of sexual activity:_____/ month

Other Conditions

- ☐ difficult digestion
- ☐ anemia
- ☐ allergies specify:_____
- ☐ gall bladder specify:_____
- ☐ kidney specify:_____
- ☐ bladder specify:_____
- ☐ liver specify:_____
- ☐ arthritis Dr. diagnosed? Yes ☐ No ☐
  circle: rhematoid / osteoarthritis
  affected areas:_____
- ☐ diabetes onset:__ __ __ __ yyyy type:_____
- ☐ hypoglycemic onset:__ __ __ __ yyyy
- ☐ epilepsy
- ☐ chronic fatigue
- ☐ cancer type:_____

Infections

- ☐ cold sores
- ☐ canker sores
- ☐ herpes
- ☐ plantar warts
- ☐ TB
- ☐ HIV, AIDS
- ☐ hepatitis type:_____
- ☐ other, specify:

Comments:

Current Health

Chief Complaint and Duration (please describe in detail):
.

Significant Illnesses (please describe in detail):

Current Medications

name	for what condition?
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Injuries

types and dates: _____

current symptons:_____

Surgerys

types and dates: _____

current symptons:_____

Current Symptons: (Please complete this page with Christopher)

Sleep:

Energy:

Sweating:

Emotions:

Chills / Fever:

Urine / Stool:

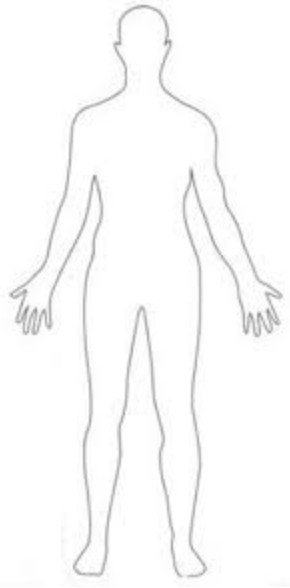
Appetite and Thirst:

Condition of the head and body:

Condition of the ears and eyes:

Condition of chest and abdomen:

Front



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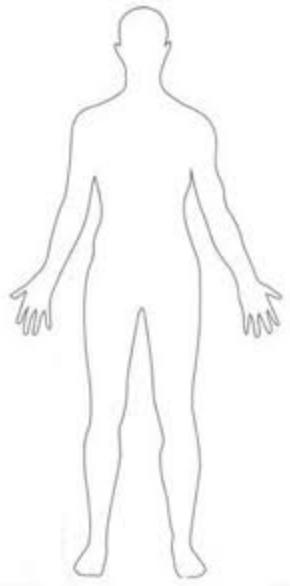


Current Symptons: (Please complete this page with Christopher)

Personal history:

Family history:

Listening and smelling:

Spirit:

Speech:

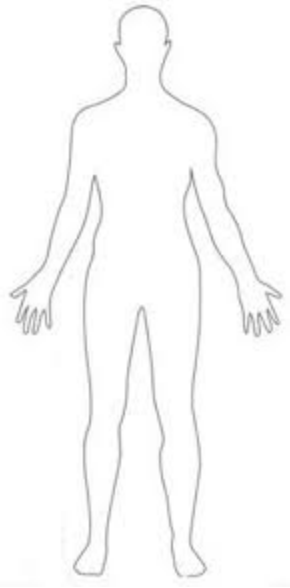
General appearance:

Body shape and movements:

Female disorders:

Menstruation and obstetrics:

Front



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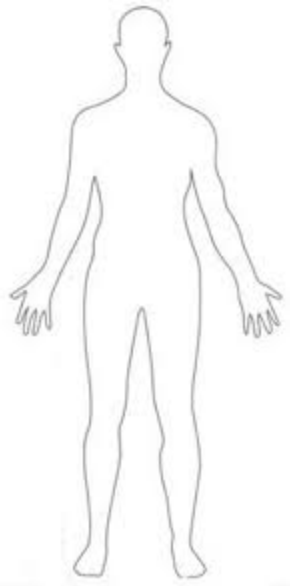

Please complete this page with Christopher

Observation of the Tongue Proper:	
Colour:	pale red, pale, red, deep red, purple
Shape:	wide, deep, rigid/hard, tender/soft, teeth marks, swollen/thin, thorny/strawberry cracks: location- direction-
Mobility:	normal, stiff, flaccid, quivering deviated, left, right, shortened, long

Observation of the Tongue Coating:	
Colour:	white, yellow, gray, black
Thickness:	none, thin, normal, thick, very thick
Root:	yes, no
Moisture:	dry, moist, very wet
Peeling:	center only, irregular, sudden

Pulse: location, strength, rate and quality

Left/Yang:	**Right/Yin:**
Cun/HT	Cun/LU
Guan/LR	Guan/SP
Chi/KI	Chi/KI

Analysis of differentiation:

Disease diagnosis:

Differentiation of syndrome:

Treatment principles:

Treatment remedies: