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:		Marital Status:
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:

Please describe the main health problem/condition you are seeking treatment for, the onset and duration and any concurrent treatments or therapies.

Past and Present Medical Conditions:

Please check off any past and present health conditions and include dates below.

□ Allergies/Asthma	□ Diabetes	□ Hepatitis/Liver Disease	□ Thyroid Disease
□ Anemia	□ Digestive Disorder	□ High/Low Blood Pressure	□ Covid-19:
□ Arthritis	□ Eating Disorder	□ HIV Positive/AIDS	
□ Cancer	□ Epilepsy/Seizures	□ Kidney Disease	□ Other:
□ CFS/Fibromyalgia	□ Heart Disease / Stroke	□ Mental Illness	
□ Depression	□ Hemophilia	□ Skin Conditions	

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

Please circle any conditions you are experiencing:

General Symptoms

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

HT Symptoms

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

LU Symptoms

Cough
Wheezing
Frequent colds
Shortness of breath
Difficulty breathing
Chest tightness
Nose and throat problems:

Repeated sore throat
Swollen glands
Sadness or grief
Cry easily
Foggy or clouded mind
Skin problems:

LR Symptoms

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:

Emotionally triggered symptoms:
Headache, poor digestion, insomnia, etc.

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

KI Symptoms

Sore/weak lower back
Sore/weak knee joint
Low sex drive
Overwork or intensive workouts
Night sweat
Teeth or hair loss
Ear problems:

Exhaustion
Afternoon crash
Fears
Addictive patterns
Abuse survivor
Lack of motivation or drive
Forgetfulness
Urinary problems:

SP/ST Symptoms

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:

Gynecology

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:

Currently Pregnant

# of weeks pregnant: _____
# of past pregnancies: _____
# of live births: _____
Delivery due date: _____

Menstrual Cycle

Date of last period: _____
Days in cycle: _____
Length of period: _____
Menstrual flow, color, clots:

Premenstrual Symptoms:

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):*

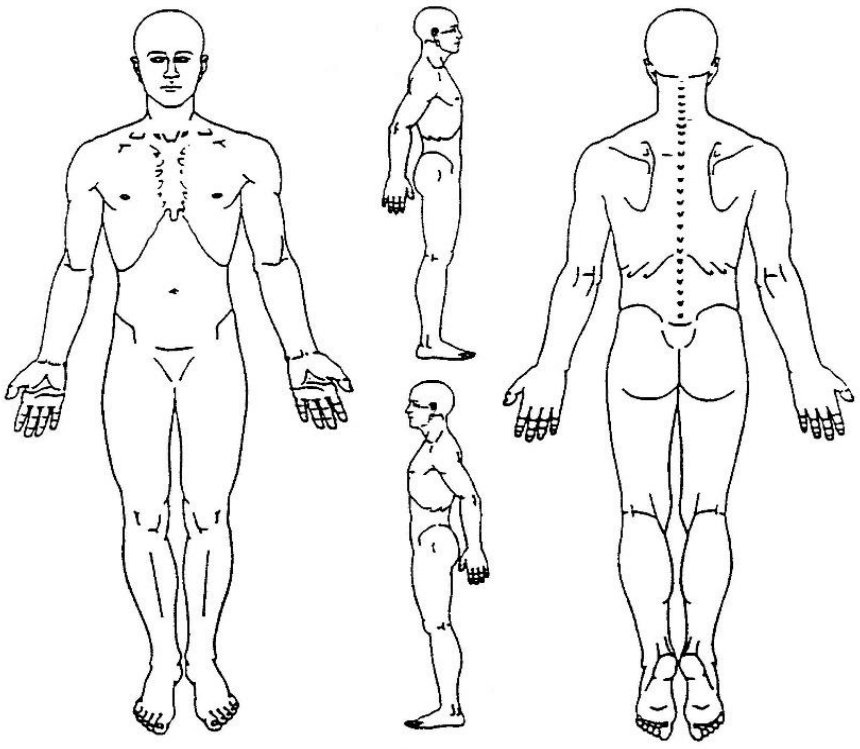
Pain Chart

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: