TAO OF HEALTH

Dr. Christopher Tornack | Doctor of Acupuncture
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5239 47A Avenue | Sylvan Lake, Alberta | T4S 1H1

GENERAL MEDICAL HISTORY

CONFIDENTIAL

Please complete every section and bring this form to your first appointment.

Your answers help us understand the whole picture and are kept confidential in your file.

Today's date: _____ Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Name: _____/_____
Last name *First name*

Age: _____ Phone: (home) _____

Birth date: _____ (cell): _____

Occupation:_____ (work) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____

Reason for today's visit: _____

_____

_____

Your family physician's diagnosis (if available): _____

Medical History:

What forms of treatment/therapy do you currently use?

☐ M.D. (name and phone number): _____

☐ Physiotherapist ☐ Massage Therapist ☐ Naturopath

☐ Chiropractor ☐ Fertility Clinic ☐ Other: _____

Have you had acupuncture before? ☐ Yes ☐ No

Chinese Herbal Medicine? ☐ Yes ☐ No

Please indicate a "P", "C" or "F" if any of the health conditions below apply to you.
P= Past C= Current F= immediate Family history

	Heart Condition		**Respiratory Disorder**		**Headaches**
	Stroke		**Kidney Disorder**		**Jaw Pain**
	High/Low Blood Pressure		**Cancer**		**Arthritis**
	Diabetes		**Hepatitis**		**Dizziness/Fainting**
	Deep Vein Thrombosis		**AIDS**		**Contagious Illness**
	Neurological Condition		**Sprain/Strain/fracture**		**Skin Condition**
	Spinal or Head Injury		**Osteoporosis**		**Digestive Problems**

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Please list prescription drugs and/or over the counter medications you are currently taking.

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

7. _____ **8.** _____ **9.** _____

Please list herbal medicines and other supplements you are currently taking.

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

7. _____ **8.** _____ **9.** _____

Please list any allergies you may have: (food, drugs, herbal and environmental).

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

Have you ever been hospitalized and/or treated for any infectious/serious condition or surgeries? □ Yes □ No

If yes, briefly explain for what condition or reason you were hospitalized and the year in which you were hospitalized: _____

_____

_____

Do you use the following? If so, how often?

Cigarettes: _____ Alcohol: _____ Drugs: _____

Please check the physical activities you participate in, and how often per week.

□ Yoga _____□ Running _____□ Fitness Class_____ □ Gym _____

□ Biking_____□ Swimming _____□ Other _____

Please inform your TCM practitioner/acupuncturist if any of the following apply to you:

Haemophiliac	**□ Yes □No**	**Epilepsy**	**□ Yes □ No**
Wear a pacemaker	**□ Yes □ No**	**Are you a vegetarian**	**□ Yes □ No**
Have a serious heart or lung condition	**□ Yes □ No**	**Do you have surgeries scheduled?**	**□ Yes □ No**
Are you taking anticoagulant medications	**□ Yes □No**	**Are you pregnant or is there a chance you may be pregnant**	**□ Yes □ No**

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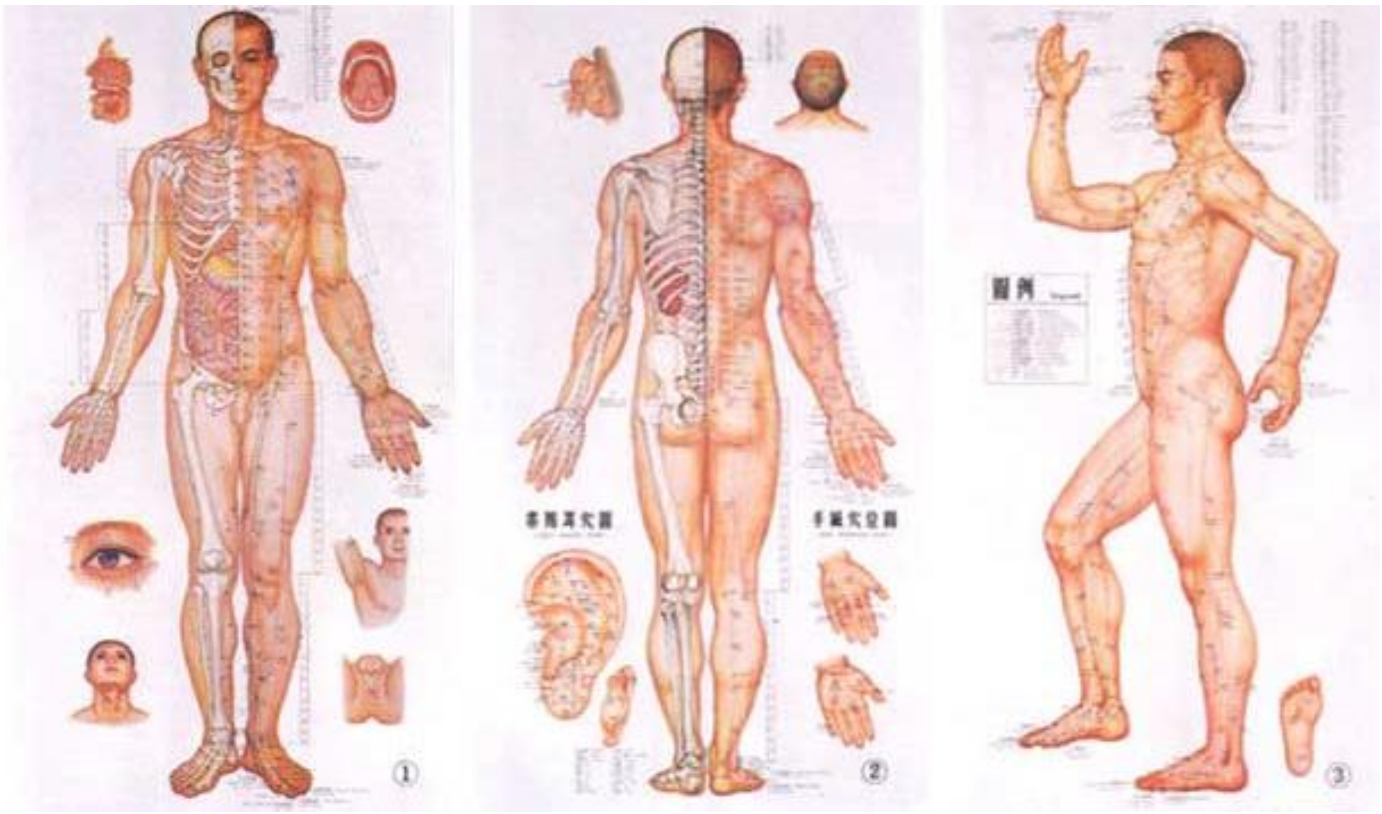
On the figures below, please circle the areas of pain/concern:



Sensations/pain: Sharp _____ Burning _____ Moves _____

Tingling _____ Dull _____ Severe _____

Shooting _____ Distending _____ Numbness _____

Any other Sensations/Pain feeling that is not listed above?

_____

_____

_____

What relieves the pain (heat/cold/massage/rest/exercise, etc.)?

_____

What aggravates the pain? (weather, heat, cold, etc.)

_____

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If you are currently experiencing these symptoms, or have been in the past 3 months, please check the appropriate squares.

Head & Neck	***Cardio Vascular***	***Ears***
☐Dizziness	☐Heart palpitations/rapid heartbeat	☐Recurring Infection
☐Fainting	☐Chest pain or tightness	☐Earaches
☐Neck Stiffness	☐Irregular Heart Beat	☐Ringing Tone: ☐high pitch ☐low pitch
☐Enlarged Lymph Glands	☐Poor Circulation	☐Wax Build up
☐Headaches/Migraines	☐Swelling of ankles	☐Decreased Hearing
☐Other_____	☐Other_____	☐Other_____

Eyes	***Nose Throat & Mouth***	***Skin***
☐Blurred Vision	☐Bleeding Gums	☐Hives
☐Visual Changes	☐Sinus Infection	☐Rashes
☐Spots/Floaters	☐Hay Fever or allergies	☐Eczema/Psoriasis
☐Flecks of Light	☐Recurring Sore throat	☐Acne
☐Eye Pain	☐Swollen Glands	☐Itching
☐Dry Eyes	☐Difficulty Swallowing/Lump in Throat	☐Dryness
☐Poor Night Vision	☐Bitter Taste in Mouth	☐Night Sweats
☐Red/burning Itchy Eyes	☐Tongue/Mouth Ulcers/Canker Sores	☐Easily/Spontaneous Sweating
☐Other_____	☐Nose Bleeds	☐Bruise Easily
	☐Dry Mouth/Thirst	☐Changes in Moles or Lumps
	☐Prefer Warm Drinks ☐Cold Drinks	☐Fine Hair/Falling out
	☐Other_____	☐Nails Break Easily/Flake Off
		☐Hot Flashes
		☐Other_____

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Respiratory	***Muscle & Joints***	***General***
☐**Chronic Cough**	☐**Joint Pain**	☐**Cold Hands and Feet**
☐**Coughing up Blood**	☐**Body Aches/Stiffness**	☐**Cold Nose**
☐**Coughing up Phlegm** **Color of Phlegm_____**	☐**Weakness**	☐**Aversion to Heat or Cold**
☐**Difficulty Breathing / Shortness of Breath**	☐**Difficulty Walking**	☐**Feel Hot or Cold**
☐**Wheezing/Asthma**	☐**Spinal Curvature**	☐**Fever and/or Chills**
☐**Frequent Colds**	☐**Numbness/Tingling**	☐**Recent Changes in Weight**
☐**Other_____**	☐**Bodily Heaviness**	☐**Fatigue**
	☐**Backache or Knee Pain**	☐**Other_____**
	☐**Other_____**	

Genito-Urinary	***Gastrointestinal***	
☐**Pain/Itching of Genitalia**	☐**Nausea**	☐**Vomiting**
☐**Genital Lesions/Discharge**	☐**Acid Reflux/Heartburn**	☐**Hiccup**
☐**Painful Urination**	☐**Gas**	☐**Bloating**
☐**Frequent Urination**	☐**Bad Breath**	
☐**Excessive or Scanty Urination**	☐**Loose/Soft Stools**	☐**Constipated/Poor Elimination**
☐**Blood in Urine**	☐**Alternate Loose/Constipation**	☐**Laxative Use**
☐**Urgent Urination**	☐**Black Stools**	☐**Bloody Stools**
☐**Unable to Hold Urine**	☐**Mucous in Stools**	
☐**Wake up to Urinate**	☐**Intestinal Pain or Cramping**	
☐**Bedwetting**	☐**Itchy Anus**	☐**Burning Anus**
☐**Increased Libido**	☐**Rectal Pain**	☐**Anal Fissures**
☐**Decreased Libido**	☐**Hemorrhoids**	
☐**Kidney Stone**	☐**Other_____**	
☐**Other_____**		

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Appetite	***Sleep***	***Emotions***
□**Normal/Healthy**	□**Sound/Restful**	□**Relaxed/Calm**
□**Ravishingly Hungry**	□**Light Sleep**	□**Sad**
□**Poor Appetite**	□**Insomnia**	□**Grief**
□**Need To Eat Several Meals**	□**Dream Disturbed**	□**Fearful**
□**Hungry, But No Desire to Eat**	□**Heavy Sleep**	□**Depressed**
□**Any Taste In The Mouth_____**	□**Wake up Easily/Early**	□**Angry/Frustrated**
Number of Meals per day _____	□**Difficulty Falling Asleep**	□**Irritable Often/Easily**
Number of Snacks_____	□**Vivid Dreams/Nightmares**	□**Anxious**
□**Other_____**	**Hrs of Sleep/Night_____**	□**Stressed**
	Bed Time _____	□**Over thinking**
	Waking _____	□**Forgetful**
Are you Pregnant? _____	□**Other_____**	□**Manic**
Are you Nursing? _____		□**Impatient**
Do you Use Birth Control? _____		□**Poor Memory**
What Type? _____		□**Other_____**

Diet

Glasses Water/Day_____ □Coffee/Day_____ □Soft Drinks/Day_____ □Artificial Sweetener/Day_____

Preferred Flavour: Sour Bitter Sweet Spicy Salty

Dislikes: _____

Lifestyle

Work: _____hrs/Week Normal Hours Irregular Hours Shift Work

_____Cigarettes/Week _____Alcohol/Week _____Caffeine/Week _____Drugs/Week

Regular Exercise_____

Occupational Stress_____

Personal Stress_____

Other Concerns Not Labeled Above _____

_____

_____

_____