**Grimsby Massage Therapy Clinic**

**Acupuncture Health History Form**

Please take the time to carefully fill out the following questionnaire. The information you provide will help to provide a complete evaluation and better assist in creating a wellness plan uniquely tailored to you.

**PATIENT INFORMATION**

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province \_\_\_\_\_\_\_\_ Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received previous acupuncture? Yes \_\_ No \_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHAT BRINGS YOU HERE**

What health concerns bring you into our office for treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other physicians/therapists seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE HABITS**

What, if any, form of exercise do you do regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does your diet consist of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the frequency you use the following per day or week:

Cigarettes (packs per day) \_\_\_\_\_\_\_\_ Coffee/Black Tea (cups per day) \_\_\_\_\_\_\_\_\_ Daily Water Intake \_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol (drinks per week) \_\_\_\_\_\_\_\_\_ Soda/Pop \_\_\_\_\_\_\_\_\_\_\_ Recreational Drugs \_\_\_\_\_\_\_\_\_\_

**MAJOR COMPLAINTS** (in order of significance to you – check what box represents the pain level)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Condition** | **Normal** | **Slight** | **Moderate** | **Severe** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

How do these conditions impair your daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY**

How was your childhood health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Visits/Stays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent tests: (please indicate test results and date below)

Physical \_\_\_\_\_ Cholesterol \_\_\_\_\_ Prostate \_\_\_\_\_ Blood \_\_\_\_\_ HIV/STD \_\_\_\_\_ Pap Smear \_\_\_\_\_ Mammography \_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Results and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any you have had in the past:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diabetes \_\_\_\_\_\_\_ | Allergies \_\_\_\_\_\_\_ | Glaucoma \_\_\_\_\_ | Rheumatic Fever \_\_\_\_\_ | Asthma \_\_\_\_\_ |
| Heart Disease \_\_\_\_\_ | Stroke \_\_\_\_\_ | Vein Condition \_\_\_\_\_ | Thyroid Disorder \_\_\_\_\_ | Pneumonia \_\_\_\_\_ |
| Emphysema \_\_\_\_\_ | Mumps \_\_\_\_\_ | Bleeding Tendency \_\_\_\_ | Measles \_\_\_\_\_ | Chicken Pox \_\_\_\_\_ |
| Nervous Disorder \_\_\_\_\_ | Meningitis \_\_\_\_\_ | HIV \_\_\_\_\_ | Mononucleosis \_\_\_\_\_ | Epilepsy \_\_\_\_\_ |
| Hepatitis \_\_\_\_\_ | Multiple Sclerosis \_\_\_\_\_ | Paralysis \_\_\_\_\_ | Cancer \_\_\_\_\_ | Migraines \_\_\_\_\_ |
| High Blood Pressure \_\_\_ |  |  |  |  |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the following that have occurred in your blood relatives:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diabetes \_\_\_\_\_ | Cancer \_\_\_\_\_ | Heart Disease \_\_\_\_\_ | High Blood Pressure \_\_ | Allergies \_\_\_\_\_ |
| Tuberculosis \_\_\_\_\_ | Obesity \_\_\_\_\_ | Bleeding Tendency \_\_\_ | Kidney Disease \_\_\_\_\_ | Alcoholism \_\_\_\_\_ |
| Nervous Illness \_\_\_\_\_ | Mental Illness \_\_\_\_\_ | Stroke \_\_\_\_\_ | Other \_\_\_\_\_ |  |

**PATIENT PROFILE**

Any areas of pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the pain:

Sharp Burning Moving Cramping Dull Fixed Aching Other

Do the following lessen the pain?

Pressure Cold Exercise Heat Other

Do the following worsen the pain?

Pressure Cold Heat

Please circle the following that pertain to you:

**Overall Temperature** (Kidney function):

Cold hands/feet Thirsty Hot body temperature Perspire easily

Cold body temperature Lack of perspiration Afternoon/night flushes Stiff neck/shoulders Overall achy feeling in the body

**Overall Energy** (Lung, Kidney function)

Shortness of breath Easily catch colds Sadness Difficulty breathing

Sore throat Low energy General weakness

**Blood** (Liver, Spleen, Heart function)

Dizziness See floating black spots

**Spleen Function**

Low appetite Weight gain/loss Bloating/gas Fatigue after eating

Prolapsed organs Easily bruised Hemorrhoids Worry

**Heart Function**

Palpitations Anxiety Chest pain traveling to shoulder

Frequent dreams Wake unrefreshed Drink Coffee

**Lung Function**

Nasal discharge Cough Nose bleeds Sinus congestion Dry mouth/throat/skin

Allergies Alternating fever and chills Headache Swollen hands/feet/joints

Chest congestion Nausea Snoring

**Spleen, Stomach, Large Intestine, Small Intestine Function**

Constipated Diarrhea Blood/mucus in stools

**Dampness Trapped in the Body**

Sensation of heaviness in body Mental fogginess Lump in the throat STD’s

Neck/shoulder tension Recreational drugs Gall stones

**Stomach Function**

Large appetite Bad breath Mouth sores Bleeding/swollen or painful gums

Heartburn/acid reflex Ulcer (diagnosed) Belching Stomach pain

Vomiting

**Liver, Gall Bladder Function**

Chest pain or tight sensation Depression Skin Rashes Unable to handle stress

Bitter taste in mouth Numbness Muscle spasms Lack of bladder control

Irritated/angry easily Fear Easily startled

**Eyes**

Itchy Bloodshot Hot Dry Watery Gritty Blurry

Decreased night vision Near-sighted Far-sighted

**Kidney, Urinary Bladder Function**

Frequent cavities Easily broken bones Sore/weak knee Urgent

Low back pain Kidney stones Bladder infections Frequent

Discharge Difficult Painful

**Libido**

Normal High Low

**Women Only:**

Regular menstrual cycle? Yes or No Pregnant? Yes or No Number of Children \_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_ Age of first menstruation \_\_\_\_\_ Age of menopause \_\_\_\_\_\_

Average number of days of flow \_\_\_\_\_ Average number of days of entire cycle \_\_\_\_\_

Please circle list horizontally

Nausea Food cravings Depression Vomiting Headaches

Irritability Water retention Migraines Anxiety Breast swelling

Breast tenderness Dull pain Sharp pain Mid-cycle pain

**Grimsby Massage Therapy Clinic**

3 Ontario Street

Grimsby, ON L3M-3G8

Phone 905.309.8694

www.grimsbymassage.com

Acupuncture Policies and Consent Form

**Fee Schedule:** 30 Minute Acupuncture $50.00 60 Minute Acupuncture & Massage $95

60 Minute Acupuncture $85.00 (All Prices Include HST)

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and MasterCard.

**Please be advised that a minimum of twenty-four hours notice to cancel an appointment is required, or you will be billed the full appointment fee. This charge also applies if you do not show up for your scheduled appointment.**

##### Privacy Policy:

Privacy of personal information is important to *Grimsby Massage Therapy Clinic*. We are committed to the collection, use and disclosure of this information in a responsible way.

In this consent form, we have outlined what our office is doing to ensure that:

* Only necessary information is collected about you;
* We only share your information with your consent;
* Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
* Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary authorized individuals who may inspect our records as part of the regulatory activities in the public interest. Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

This office will collect, use and disclose information about you for the following purposes:

* To deliver safe and effective patient care
* To enable us to contact you
* For teaching and demonstrating on an anonymous basis
* To complete and submit claims on your behalf to third party payers
* To comply with legal and regulatory requirements under the Massage Therapists Act and the Regulated Health Professions Act
* To process payments and collect unpaid accounts
* For research purposes

By signing the policies and consent form, you have agreed that you have reviewed and understand your financial responsibility and agree to the terms stated in this policy. You are also agreeing that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed.

**I have read and understand the above policies and consent and agree to abide by these conditions. I agree to Massage Therapy Assessment and Treatment. I agree that *Grimsby Massage Therapy Clinic* can collect, use, and disclose my personal information as set out above in the privacy code. I also understand the purpose for disclosing this personal information so that *Grimsby Massage Therapy Clinic* may complete and submit claims on my behalf to third party payers. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.**

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(Patient Signature) (Date) (Witness Signature)