# TAO OF HEALTH

**Christopher Tornack**
**Registered Acupuncturist, Reflexologist**
email christopher@toatcmhealth.com - phone 403.896.9726
- address 5239 47A Avenue • Sylvan Lake, Alberta T4S 1H1

## General Medical History CONFIDENTIAL

**Please check boxes, circle or fill in where applicable**

*To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information will be 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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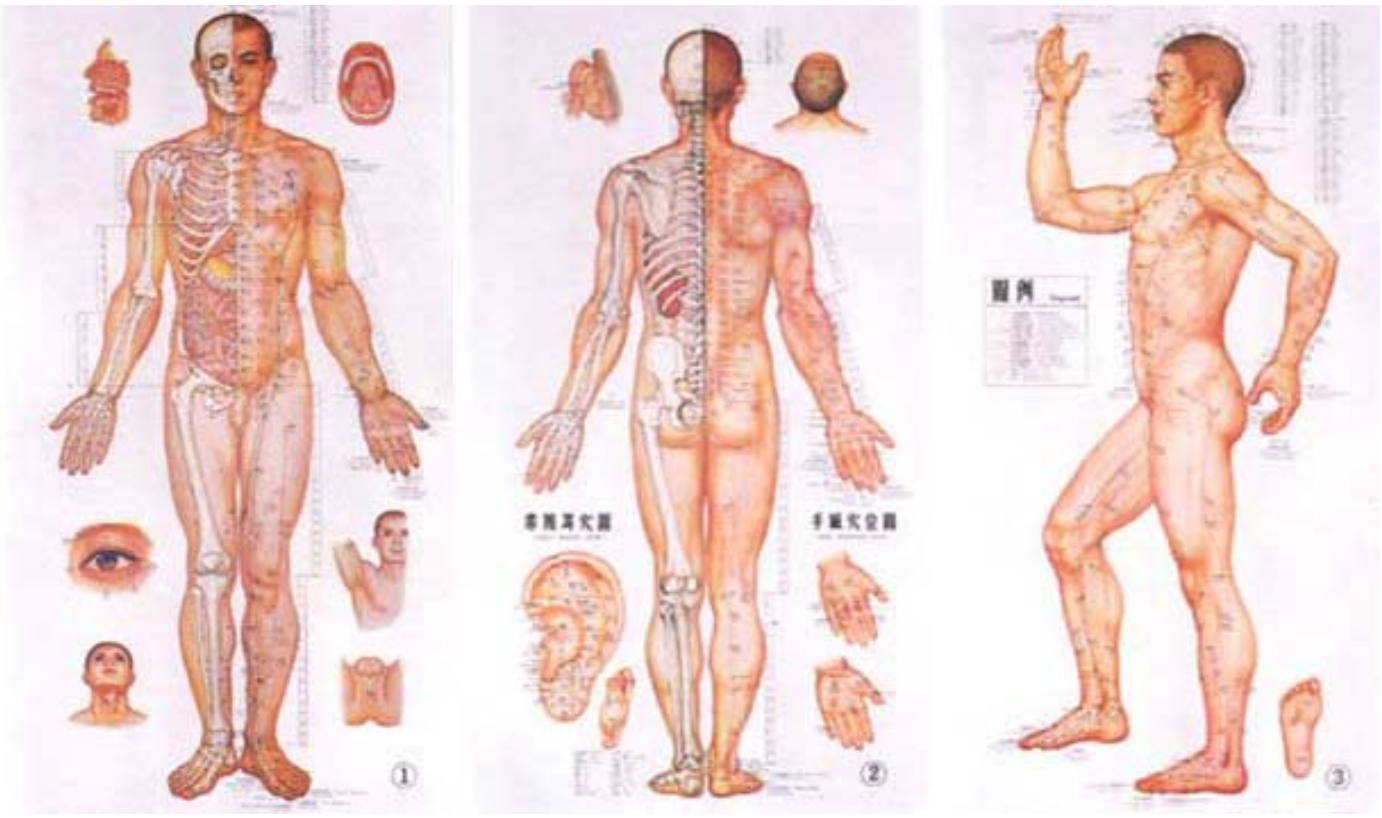
**On the figures below, please circle the areas of pain/concern:**



**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**<br>**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 _____**

_____

_____

_____