TONUME INTEGRATED HEALTH ACUPUNCTURE & TCM HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have any questions, please ask. Thank You.

Name: _____ **Birth Date**:_____(YYYY/MM/DD)
Address: _____ **Family Doctor:** _____
_____ **Phone:** _____
Postal Code: _____ **Referring Professional:** _____
Phone: (home): _____ **Phone:** _____
(Cell): _____ **Emergency Contact Name:**_____
E-mail Address: _____ **Phone:** _____
Care Card Number: _____
Is this an ICBC Claim? Yes / No **If yes, Claim #:** _____
Is this a WCB Claim? Yes / No **If yes, Claim #:** _____
How did you hear about us? Circle all that apply – Referral – Internet – Word of Mouth – Walking By – Newspaper
Have you had Acupuncture or used TCM treatments before? Yes / No
If yes, for what? _____
When was the last treatment? _____(YY/MM/DD)
WHAT IS THE **PRIMARY REASON** FOR YOUR VISIT TODAY? _____
_____
When did you ***first notice*** any symptoms? _____
Have you experienced these symptoms before? _____
Is this condition getting **BETTER**, getting **WORSE**, or **STAYING THE SAME ?** (circle one)
Have you been given a ***diagnosis*** for this condition by another physician? Yes / No
If YES, what was the diagnosis? _____
Have you received any ***previous treatment*** for this condition? Yes / No
If YES, by WHOM, and did it help? _____
Is your present condition the result of a single ***traumatic event***? Yes / No
If YES, please describe in detail what happened: _____
_____

SYMPTOMS OF THE PRESENT CONDITION:

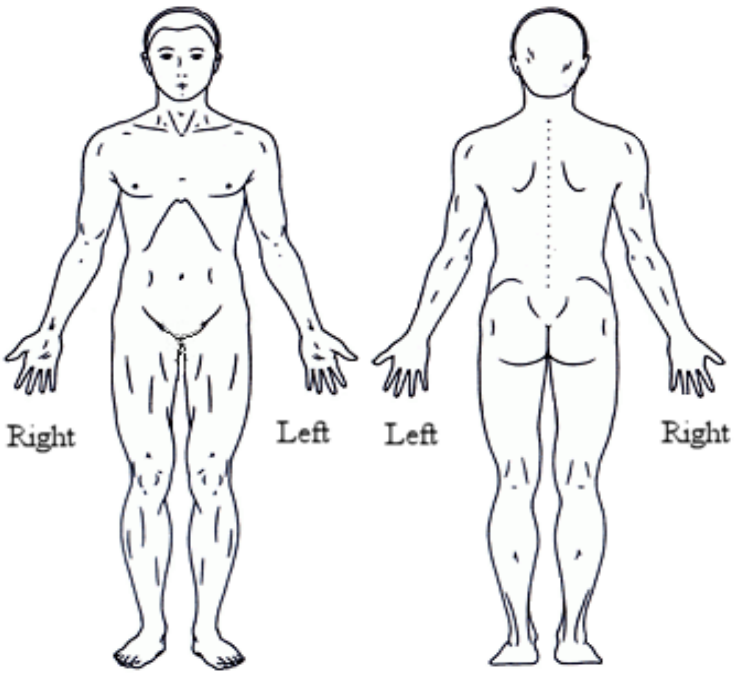
Mark the area(s) on the diagrams where you feel the described sensations.

Use the appropriate symbols

Please include all the affected areas, including regions of radiating pain, numbness and tingling

Sharp Pain: **XXXXXX**
Dull Aching: **000000**
Numbness or pins & needles: ///////

**Other sensations: please mention to the doctor during the initial examination.



Please rate on a scale of 0-10 below to indicate the intensity of your pain today

NO PAIN 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 **UNBEARABLE PAIN**

Does the pain radiate from the area of your primary complaint? Yes / No
If YES, where does it radiate to? _____
Is the pain constant? Yes / No - If the pain comes and goes, ***how often*** do you experience the symptoms?
_____/day _____/week _____/month _____/year
What makes your condition ***feel better***? (please check ✓ if applicable)
☐rest ☐ice ☐heat ☐stretching ☐exercising ☐medication
☐other: _____
Is the pain worse in the **MORNING, AFTERNOON** or **EVENING**? (circle if applicable)
Does the pain prevent you from **sleeping**? Yes / No If YES, how much per night? _____
Do you regularly sleep on your **STOMACH, SIDE** or **BACK**? (circle if applicable)

MEDICAL HISTORY: (Please check✓ all symptoms and signs occurring presently or within the past 12 months)

Women's health

☐hot flashes ☐vaginal dryness ☐breast tenderness ☐mood swings ☐bloating ☐night sweats
☐irritability/impatience ☐headaches ☐cramping ☐clots
Starting Date of last menstrual period (if applicable): _____

Men's health

☐urinary pain ☐urinary urgency ☐urinary hesitancy ☐low libido ☐hernia ☐prostate problems
☐discharges/sores ☐sexual difficulties ☐testicular mass/pain
Date of last prostate exam (if applicable): _____

General

☐gaining weight ☐losing weight ☐cold intolerance ☐hot intolerance ☐daytime sleepiness
☐early waking ☐insomnia ☐fatigue ☐fever

Head/Eyes/Ears

☐headache/migraines ☐ear pain ☐ear buzzing/ringing ☐changes in hearing ☐itchy/watery eyes
☐changes in vision ☐eye pain

Musculoskeletal

☐low back pain ☐foot cramps/pain ☐joint deformity ☐joint pain/stiffness ☐muscle pain
☐muscle weakness ☐muscle spasms/cramps ☐tendonitis ☐TMJ problems ☐tension headaches

Skin/Nails

☐acne (face/torso) ☐athlete's foot/jock itch ☐dandruff ☐bumps on arms ☐cellulite
☐dark circles under eyes ☐lack of sweating ☐sweating easily ☐eczema/hives/rash ☐psoriasis
☐oily skin ☐itchy skin ☐dry skin ☐suspicious moles ☐changes in pigment ☐skin darkening
☐hair loss ☐finger clubbing ☐ridging/spots on nails ☐soft nails ☐thickening of nails

Gastrointestinal

☐bloating ☐constipation ☐diarrhea ☐blood or mucus in stool ☐pain with stool
☐cramps/indigestion ☐flatulence ☐belching ☐acid reflux ☐haemorrhoids ☐anal fissures
☐undigested food in stool ☐food intolerances ☐jaundice ☐nausea

Other: _____

Respiratory

☐breathlessness ☐exercise intolerance ☐dry cough ☐productive cough ☐hoarseness
☐seasonal allergies ☐nasal congestion ☐snoring ☐wheezing/asthma ☐sore throat

Cardiovascular

☐chest pain/angina ☐palpitations ☐irregular pulse ☐easy bruising ☐varicose veins
☐swollen ankles/feet ☐high blood pressure ☐low blood pressure ☐cold hands and feet

Urinary

☐UTI ☐incontinence/dribbling ☐discomfort on urination ☐frequent urination ☐blood in urine

Other: _____

Lymph/Immune System
☐enlarged lymph nodes ☐painful/tender nodes ☐swelling of extremities ☐frequent infections
☐slow wound healing

Mind/Nervous System
☐anxiety ☐depression ☐irritability/impatience ☐difficulty in concentration ☐poor memory
☐fearful/chronic worry ☐panic attacks ☐numbness/tingling ☐speech difficulty
☐seizures ☐tremor/trembling ☐dizziness/vertigo ☐light headed/fainting ☐loss of balance

Eating/Appetite
☐frequent dieting ☐poor appetite ☐always hungry ☐emotional eater ☐salt cravings
☐carbohydrate cravings ☐sugar cravings ☐caffeine-dependent ☐binge eating ☐bulimia/anorexia

Have you ever had any previous Injuries, Trauma, Surgery or Major Illnesses? Yes / No
If YES, please describe: _____
Please provide details of your daily diet – frequency of meals, types of foods and food intolerances
_____

How often are the following products consumed? (please check ✓ if applicable and describe frequency)
☐Water: _____ ☐Tea: _____ ☐Coffee: _____ ☐Pop/Sugary Drinks :_____
☐Drugs: _____ ☐Other: _____
Are you taking any ***medications***? Yes / No If YES, what are they? _____
Do you ***smoke*** cigarettes/cigars? Yes / No If YES, how many per day? _____
Do you ***drink*** alcohol? Yes / No If YES, how much per week? _____
What do you do for ***exercise***? _____
How often do you exercise per week? _____
Please provide details of your Exercise – type of exercise, frequency and intensity: _____
_____

FAMILY MEDICAL HISTORY: (please specify family member)

_____
_____

Have you, or anyone in ***your family***, experienced any of the following ***conditions***?

CONDITION:	DESCRIBE
☐ Bleeding Diseases	
☐ Blood Thinners Taken	
☐ Positive STD's/HIV/AIDS	
☐ Hepatitis B or C	
☐ Allergies (medications, chemicals, foods etc)	
☐ Latex Allergies	
☐ Other – Please Specify	

If there is any other information regarding your present condition that you think would help us, please describe:
_____
_____

I confirm the health and medical information given above to be accurate. As well, I understand the therapeutic benefits and possible side-effects of the treatment that may be recommended for my condition and for any future conditions for which I seek treatment, and I consent to the proposed treatment by Bok Hing Chen.

Signature:_____ **Date:**_____(YYYY/MM/DD)

I would like to receive Tonume's quarterly e-news letter, monthly clinic updates and special offers. Yes No
Your email address will be used by Tonume only, and are kept strictly confidential