HEALTH KINECTIONS

A Total Approach to Health and Wellness

Dr. Karen Brust

TRADITIONAL CHINESE MEDICINE HEALTH HISTORY

Name ______________________________ Date ______________

Date of birth ______________ (M/D/Y) Height: ______ Weight:______ Sex: M F

Address:____

City: ________________ Province: __________ Postal Code: ____________

E-mail Address: ______________________________________

Ph: (H) ☐______________ (W) ☐______________ (C) ☐______________

(Check your preferred phone number above)

Emergency contact: Name: ______________________________

Phone number: ________________ Relation:________________

E-Mail Address: __________________ Check if you want to receive any of the following through e-mail:

☐ Appointment Reminders ☐ Health Newsletters ☐ Special Offers ☐ Special Events

How did you find out about us?

☐ Healthcare Provider ☐ Lawyer ☐ Employer ☐ Clinic Materials
☐ Special Event ☐ Here Before ☐ Website ☐ Special Offer
☐ Can Pages ☐ Yellow Pages ☐ Family/Friends ☐ Signage

Who referred you?

____

Other health care providers you are seeing:

1.______________________ 2.______________________
3.______________________ 4.______________________

What are your health concerns, in order of importance to you?

1. ______________________ 4.______________________
2. ______________________ 5.______________________
3. ______________________ 6.______________________

What is the goal of your visit today?

____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Medical History

How would you describe your general state of health? □Excellent □Good □Fair □Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

____

____

Please list all current medications and supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

____

____

Please list past prescription medications.

____

____

When was the last time you were treated with Antibiotics? ____________

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills

Alcohol—how much/day or week ____________

Tobacco—form and amount/day ____________

Caffeine—form and amount/day ____________

Recreational drugs—what and how often ____________

Please indicate what immunizations you have had.

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A

☐ Tetanus booster; when? ____________ ☐ "Flu" ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox

Other: ____________

Any adverse reactions?: ____________

____

Do you get regular screening tests done by another doctor (Pap, blood tests, etc)? Y / N

If you are female, are you currently pregnant? □Yes □No

Please list allergies and your symptoms to allergen exposure: ____________

____

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Environment

Occupation: ______________________________

Hobbies: ______________________________

Do you exercise regularly? ☐Yes ☐No What do you do for exercise, how much, how often? ______________________________

____

Are you exposed to significant tobacco smoke (work, home, etc.)? ☐Yes ☐No

Are you frequently exposed to animals (work, pets, etc.)? ☐Yes ☐No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?

Please describe: ______________________________

____

Sleep Habits - ☐ 1-4 hr ☐ 4-6 ☐ 6-10 ☐ more than 10

Hours per night ____ Do you wake refreshed? ________ If not, Why?______________

Do you have problems: ☐falling asleep ☐staying asleep ☐waking up

Energy Levels (average per week; circle one)

1 2 3 4 5 6 7 8 9 10

(Lowest energy) (Highest energy)

Stress Levels (average per week; circle one)

1 2 3 4 5 6 7 8 9 10

(Lowest stress) (Highest stress)

How do you cope with stress? ______________________________

Who do you talk with about your problems? ______________________________

What do you do for fun and how often? ______________________________

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Below are groups of symptoms. Please identify any that you may have experienced in the last 6 months with an "R" (recent), those long ago with a "P" (passed). Please also indicated number of times you have experienced them.

GENERAL:

__Poor appetite
__Poor sleep
__Fatigue
__Cravings
__Strong thirst
__Sudden Energy Drop (time of day) ____________
__Night sweats
__Sweat easily
__Change in appetite
__Bleed/bruise easily
__Peculiar taste/smells
__Weight gain
__Weight loss
__Chills
__Fevers

SKIN AND HAIR:

__Rashes
__Loss of Hair
__Acne
__Recent changes in moles
__Change in skin/hair texture
__Ulcerations
__Non-healing wounds
__Itching
__Dandruff
__Eczema
__Warts

HEAD, EYES, EARS, NOSE AND THROAT:

__Headaches
__Neck pain
__Concussion Dx By?________
__Eye pain
__Eye strain
__Blurry vision
__Using glasses
__Foaters
__Night blindness
__Colour blindness
__Cataracts
__Earaches
__Poor hearing
__Ringing in ears
__Sores on lip/tongue
__Mouth
__Sinus problems
__Nose bleeds
__Jaw pain
__Tooth pain
__Mercury fillings
__Sore throat
__Facial pain

CARDIOVASCULAR:

__High blood pressure
__Low blood pressure
__Irregular heartbeat
__Dizziness
__Fainting
__Chest pain
__Varicose veins
__Blood clots
__Cold hands/feet
__Swelling of hands
__Swelling of feet

RESPIRATORY:

__Difficult breathing
__Cough
__Bronchitis
__Asthma
__Pain with a deep breathe
__Production of Phlegm
__Coughing blood
__Pneumonia
__Other

WAIVER

The undersigned acknowledges:

Consent to release information

I hereby authorize and grant permission to my health care provider to carry out such examinations, procedures, and treatment as deemed necessary or as ordered by my physician.

I am informed that no procedure will be conducted without full explanation of the reason and method relating to the procedure and advice of risk (if any) and the probability for successful outcome.

Consent for Liability and Cost

I hereby acknowledge and understand that I am personally liable for any cost incurred by myself at Health Kinections under Dr Karen Brust.

Name ______________________ **Witness**______________________

(please print) **(please print)**

Name ______________________ **Witness** ______________________

Date ______________________ **Date** ______________________

PATIENT CONSULTATION FORM

Section 8(1) of Alberta's Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless:

(a) that a person has already consulted with a physician or, in the case of dental pathology, a dentist about the condition for which treatment from the acupuncturist is being sought;

(b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition;

(c) the acupuncturist has completed a patient consultation form.

Name of Acupuncturist: **Dr Karen Brust**

Office/Business address: **#224, 6707 Elbow Dr. SW Calgary, AB T2V 0E4**

Name of Patient: ______________________________

Date of Consultation with Acupuncturist ______________________________

Has the Patient consulted with a Physician or Dentist (as appropriate) about the condition for which acupuncture treatment is now being sought?

_____ **YES** _____ **NO**