New Leaf Kinetic Arts

PATIENT HEALTH HISTORY

Name: ______________________ Date of Birth: ______________________
Provincial Health Number: ______________________ Smoking: Yes ☐ No ☐ Cigarettes/day ______________
Address: ____
Occupation: ______________________ Work Phone #: (____) ______________________
Home #: (____) ______________________ Cell #: (____) ______________________
Email: ______________________ Referred by: ______________________
Marital Status/Children: ____
Physician's Name & Number: ____

WOMEN: Are you pregnant? Yes ☐ No ☐. If so, please indicate your due date: ______________________

Do you have any allergies? ____
Please list any medications: ____
If you are under medical supervision, please indicate for what condition(s): ______________________
____

Is your injury the result of a Motor Vehicle Accident? Yes ☐ No ☐. Have you made an SGI injury claim? ________
Do you suffer from back pain? If so, what area(s)? ____
Have you been to a Registered Massage Therapist or Acupuncturist before? ______________________
When was your last treatment? ____
Reason for today's treatment: ____

Please indicate the treatments you have received so far for your pain (P) or maintenance (M):

Massage Therapy ☐ Osteopathy ☐ Medication ☐ Acupuncture ☐
Physical Therapy ☐ Relaxation ☐ Chiropractic ☐ Stretching ☐
Other treatments ☐: ____

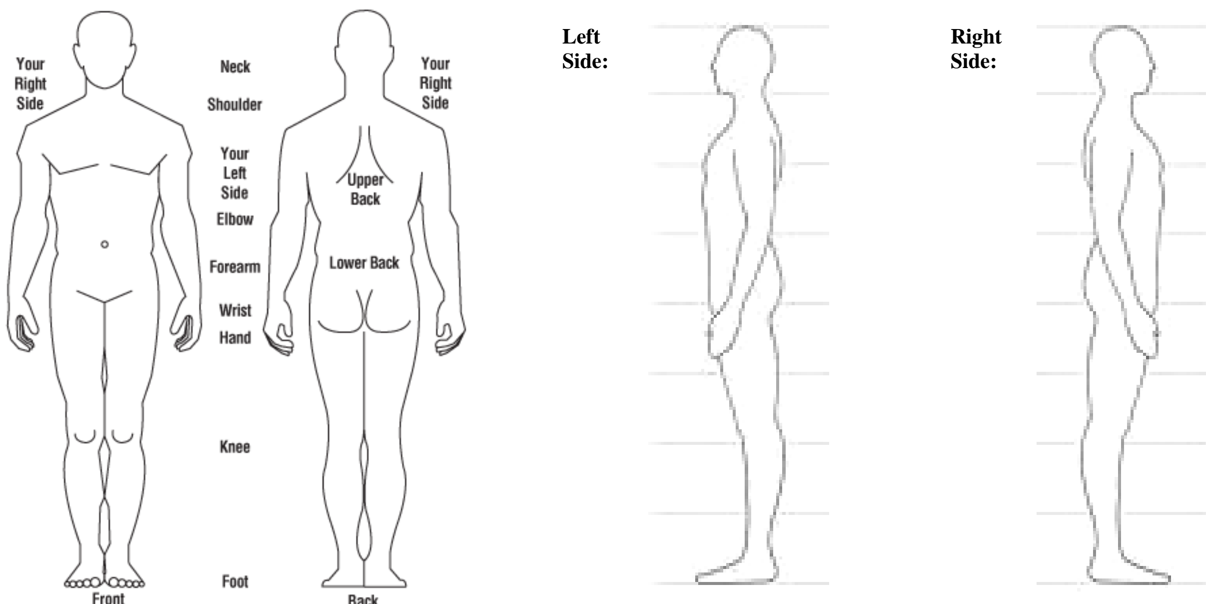
So far, which treatments have benefitted you the most? ______________________

What type of exercise do you do daily? weekly? ______________________

Please mark in the scale of what your level of pain is today (T) and in general (G):

(0 = no pain) 0——1——2——3——4——5——6——7——8——9——10 (10 = worst pain)

Please use the following drawings to mark the areas where you have pain:



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PATIENT HEALTH HISTORY

Has anyone in your family had: Heart Disease? ☐ High Blood Pressure? ☐ Diabetes? ☐ Cancer? ☐ Other Diseases? ☐ Specify whom: ______________________________

Please check any appropriate symptoms that you have experienced persistently:

Head & Neck

Headaches ☐	Hearing Problems ☐	Tinnitus (Ringing of the Ears) ☐
Vertigo ☐	Dizziness ☐	Eye Problems ☐
Vision Problems ☐	Nose Problems ☐	Temporomandibular (Jaw) Problems ☐
Sinusitis ☐	Cavities ☐	Other Mouth Problems ☐
Sore throat ☐	Neck Pain ☐	Voice Changes ☐

Other problems in these areas: ______________________________

Chest, Lungs, Heart & Skin

Chest Pain ☐	Palpitations ☐	Blood Pressure Problems: ☐ High ☐ Low
Tachycardia ☐	Chest Oppression ☐	Excessive Dreaming ☐
Insomnia ☐	Night Sweats ☐	Excessive or Little Sweating ☐
Lung Problems ☐	Asthma ☐	Shortness of Breath ☐
Allergies ☐	Skin Problems ☐	Restlessness or Irritability ☐

Other problems in these areas: ______________________________

Digestive System & Miscellaneous

Bleeding Gums ☐	Belching ☐	Nausea or Vomiting ☐
Heartburn ☐	Poor Appetite ☐	Loss of Taste ☐
Bloating ☐	Abdominal Pain ☐	Bowel Movements after Meals ☐
Sleepy after Meals ☐	Gas or Rumbling ☐	Diarrhea ☐
Constipation ☐	Hemorrhoids ☐	Gaining or Losing Weight Easily ☐
Bruising Easily ☐	Heavy Legs ☐	Varicosities ☐

Other problems in these areas: ______________________________

Gynecological System

Painful Periods ☐	Heavy Periods ☐	Irregular Periods ☐
Long Periods ☐	Absent Periods ☐	Pre-Menstrual Syndrome ☐
Hot Flashes ☐	Endometriosis ☐	Painful Intercourse ☐
Fertility Problems ☐	Breast Problems ☐	Miscarriages or Abortions ☐

Other problems in these areas: ______________________________

Liver & Gall Bladder

Liver Problems ☐	Sweaty Palms ☐	Sweat Easily ☐
Irritated Easily ☐	Brittle Nails ☐	Bitter Taste in Mouth ☐
Muscle Cramps ☐	Anxiety ☐	Tension Headaches ☐
Slow Digestion ☐	Restlessness ☐	Stiff Joints & Muscles ☐

Other problems in these areas: ______________________________

Kidney, Urinary Tract, Endocrine System & Various

Kidney Stones ☐	Kidney Problems ☐	Urinary Bladder Problems ☐
Prostatitis ☐	Frequent Urination ☐	Urinary Tract Infections ☐
Incontinence ☐	Low Sexual Drive ☐	Erectile Dysfunction ☐
Feeling Cold ☐	Feeling Hot ☐	Feeling Low Energy ☐
Cold Hands ☐	Cold Feet ☐	Joint Pain ☐
Weak or Sore Knees ☐	Low Back Pain ☐	Bone Problems ☐: ______________

Other problems in these areas: ______________________________

Please mention any muscle/joint dysfunction or any other problems anywhere else:

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