HEALTH HISTORY & ASSESSMENT

Christopher M. Di Tecco R.Ac, R.TCMP #2252
1435 Thetford Court, Mississauga ON L5J 3N2 (647)388-2140

All information communicated to the practitioner is private and confidential and will not be disclosed without the express permission of the client.

PERSONAL INFORMATION

Name:	Date: DD / MM / YY
Address:	DOB: DD / MM / YY
City:	Gender:
Province:	Age:
Postal Code:	Email:
Home Phone:	Cell Phone:
	Emergency #:

Employer:	Occupation:
Address:	Work Phone:

Family Doctor:	Phone Number:
Address:	

Who may we thank for referring you? ______________________________________

Would you like to receive our monthly email newsletter? Yes _____ No_____

List your chief complaint in order of severity:
1) ____ For how long? ____________
2) ____ For how long? ____________
3) ____ For how long? ____________

What do you hope to achieve with your treatment?

Are you currently being treated by other health care providers?

Name/type of practitioner: __________________________________

Date of your last physical examination: ______________________________________
List previous diagnoses given: ______________________________________
List operations you have had: ______________________________________
List serious illnesses you have had: ______________________________________
List medications that you currently take: ______________________________________

List any special nutrition/supplements: ______________________________________
List any exercise or activity: ______________________________________

Height:	Weight:

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How would you rate your current level of health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Please mark the following conditions you have had presently (√) or in the past (x):

PAST CONDITIONS
☐ Pneumonia
☐ Rheumatic fever
☐ Polio
☐ Tuberculosis
☐ Whooping cough
☐ Anaemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Diabetes
☐ Heart Disease
☐ Thyroid Problems
☐ Pleurisy
☐ Arthritis
☐ Epilepsy
☐ Mental Disorders
☐ Lumbago
☐ Eczema
☐ Hepatitis/Liver disease
☐ Rheumatic Fever/Autoimmune
☐ Kidney Disease
☐ Eating Disorders
☐ Cancer
☐ HIV/AIDS

GENERAL
☐ Allergies
☐ Fever
☐ Headaches
☐ Skin Problems
☐ Hair Problems
☐ Do you catch colds often?

DIET INTAKE:
☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar
☐ Pop

ENERGY LEVELS
☐ Are you easily fatigued?
☐ Do you need to take naps?
☐ Do you generally feel cold?
☐ Do you have cold feet?
☐ Do you have cold hands?
☐ Excessive Sweating
☐ Spontaneous Sweating
☐ Do you experience low grade fever?
☐ Do your hands and cheeks warm up easily?
☐ Do you wake up sweating during the night?

MUSCULO-SKELETAL
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain
☐ Joint Stiffness
☐ Walking Problems
☐ Clicking Jaw
☐ Difficulty Chewing
☐ General Stiffness

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SLEEP PATTERNS
 Insomnia
 Difficulty Falling Asleep
 Difficulty Staying Asleep
 Restless Sleep
 Excessive Dreaming

NERVOUS SYSTEM
 Nervousness
 Numbness
 Paralysis
 Dizziness
 Forgetfulness
 Confusion
 Depression
 Fainting
 Convulsions
 Cold Extremities
 Tingling Extremities
 Stress

ENT
 Vision Problems
 Dry Eyes
 Dental Problems
 Sore Throat
 Ear Aches
 Hearing Difficulty
 Nasal Congestion

C-V-R
 Chest Pain
 Shortness of Breath
 Blood Pressure Problems
 Irregular Heart Beat
 Heart Problems
 Lung Problems
 Varicose Veins
 Ankle Swelling
 Stroke

URINARY
 Bladder Trouble
 Painful Urination
 Excessive Urination
 Discoloured Urine

GASTRO-INTESTINAL
 Poor/Excessive Appetite
 Excessive Thirst
 Nausea
 Vomiting
 Diarrhoea
 Constipation
 Hemorrhoids
 Liver Problems
 Gallbladder Problems
 Weight Trouble
 Abdominal Cramps
 Gas/Bloating
 Heartburn
 Black/Blood Stool
 Colitis

FEMALES ONLY
 Your last period? _______________
 Age of first menses?______________
 How long is your cycle?______________
 Menstrual Irregularity
 Menstrual Cramps
 PMS
 Vaginal Pain/Infection
 Breast Pain/Lumps
 Sexual Dysfunction
 Infertility
 Birth Control Methods
(if any)?_______________
 Are you pregnant?
 Number of pregnancies:___________
 Number of births: ____________
 Other Problems

MALE ONLY
 Prostate Problems
 Sexual Dysfunction
 Impotency
 Other Problem

Family Health History:
Please advise of any hereditary health conditions/concerns of your parents, siblings, children and/or spouse:

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Consent Form

I, or the person listed below, have discussed with my Traditional Chinese Medicine Practitioner the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine (TCM)/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques under the scope of TCM include the use of sterile, single use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping, moxibustion and tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of unforeseen risks I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis. In some cases where cross infection is high, my practitioner may withhold treatment.
5. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for full and prompt payment after services have been rendered. I understand there is a cancellation policy and that 24 hours notice is required to reschedule or cancel my appointment, or I will be charged the full fee. I understand that this policy is implemented in order to accommodate other patients waiting for an appointment.
6. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for TCM treatments.

Patient Signature:____ Date:_______________

Patient's Name (print):____

Practitioner's Signature:____ Date:_______________

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Consent to Collect and Release Information

I, __________________________, or my appointed representative____________________
Print Name Print Name

☐ Consent ☐ Do Not Consent

For Christopher M. Di Tecco to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel if necessary.

In terms of information, Christopher M. Di Tecco may collect any of the following:

- Contact information
- Personal or family medical information
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used
Your personal information can be used for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information
I understand that my personal and medical history is available for me to review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

Acknowledgement
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions:____

____

Patient Signature:____ Date:______________

Witness:____ Date:______________