ALLISON KUCAN HAHN, B.SC.(HONS), R.AC, R.TCMP
Registered Acupuncturist & Traditional Chinese Medicine Practitioner
CTCMPAO #1110

KUCAN CHIROPRACTIC & ACUPUNCTURE CLINIC

285-12th Street, Hanover, ON · 519-364-3020 · info@kucanclinic.com

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile and Chinese Medicine diagnosis for you. All of your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets. **PLEASE RETURN THESE FORMS NO LATER THAN 24 HOURS BEFORE YOUR INTIAL APPOINTMENT, IF POSSIBLE.** Thank you.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Is it OK to leave a message at home? YES/NO On your cell? YES/NO At work? YES/NO

Referred by: _____ Physician: _____

Emergency Contact: _____ Phone: _____

Have you ever had acupuncture before? YES/NO

Have you ever taken Chinese herbal medicine before? YES/NO

If yes, please tell me what the experience was like.

MAIN CONCERN (Symptoms? Diagnosis? When and how did it start?)

What makes your condition BETTER? (Rest, movement, heat, cold, fresh air, crying, weather, etc.)

What makes your condition WORSE? (Stress, fatigue, hunger, position, heat, cold, foods, weather, time of day/month, etc.)

What other interventions have you tried? (Doctors, tests, therapies, medications, supplements, etc?)

YOUR MEDICAL HISTORY:

Significant Accidents or Traumas (physical and/or emotional)

Surgeries (including dates)

Medications (including names & dosages; please attach an additional page if necessary)

Vitamins/Supplements/Herbs (please attach an additional page if necessary)

PERSONAL HEALTH HISTORY (Please check any condition or symptoms that YOU HAVE NOW, OR HAVE EVER HAD IN THE PAST)

- o Addiction
- o Allergies
- o AIDS/HIV
- o Anemia
- o Appendicitis
- o Asthma
- o Autoimmune disease
- o Birth trauma (your own birth)
- o Bleeding disorder
- o Cancer
- o Chicken pox
- o Chronic fatigue
- o Chronic pain
- o Crohn's/Colitis
- o Diabetes
- o Diverticulitis
- o Epilepsy
- o Food allergies/intolerances
- o Gastritis/pancreatitis
- o Heart attack
- o Heart disease
- o Hepatitis
- o Herpes
- o High blood pressure
- o High cholesterol
- o Irritable bowel syndrome
- o Kidney disease
- o Liver/gallbladder disease
- o Low blood pressure
- o Low blood sugar
- o Lung disease
- o Lyme disease
- o Measles
- o Multiple sclerosis
- o Mumps
- o Osteoarthritis
- o Pacemaker
- o Polio
- o Rheumatoid Arthritis
- o Rheumatic fever
- o Scarlet fever
- o Seizure
- o Stroke
- o Thyroid disorder
- o Tuberculosis
- o Ulcers
- o Whooping cough
- o Other _____

EXERCISE

Days per week? _____ Types of activities? _____ Length of workout? _____

LIFESTYLE

Meals per day? _____ Snacks? _____ Caffeine? _____ Water? _____

Alcohol per week? _____ Smoking/Vaping? _____ Recreational drugs? _____

FAMILY MEDICAL HISTORY (Please check any condition THAT APPLIES TO YOUR IMMEDIATE FAMILY. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) in the blank.)

- o Addiction _____
- o Allergies _____
- o Asthma _____
- o Cancer _____
- o Diabetes _____
- o Heart disease _____
- o High blood pressure _____
- o Thyroid disorder _____
- o Seizures _____
- o Stroke _____
- o Other _____
- o _____

Please CHECK if you have had any of the following symptoms IN THE LAST YEAR.
Please CIRCLE if you have had any of the following symptoms IN THE PAST, BUT DON'T ANY LONGER.

GENERAL

- o Poor appetite
- o Insomnia/poor sleep
- o Shift work
- o Fatigue
- o Dizziness
- o Sudden energy drop
- o Weakness
- o Heaviness
- o Chills/Cold
- o Feverishness/Heat
- o Night sweats
- o Sweats for no apparent reason
- o Localized sweats/clamminess
- o Tremors/tics
- o Poor balance/frequent falls
- o Cravings
- o Strong Thirst (Hot/Cold drinks)
- o Change in appetite
- o Bleed/bruise easily
- o Weight loss
- o Weight gain

SKIN AND HAIR

- Rash
- Itching
- Dryness
- Eczema/psoriasis
- Dandruff
- Hair Loss
- Recent moles
- Skin discoloration
- Acne
- Change in hair/skin texture
- Face flushing
- Ulcerations
- Hives/Allergic Dermatitis
  Warts
- Fungal infection
- Weak/ridged nails

HEAD, EYES, EARS, NOSE AND THROAT

- Eye strain/pain
- Eye redness/itching/dryness
- Poor/blurry vision
- Glasses
- Poor night vision
- Color blindness
- Floaters
- Cataracts
- Glaucoma
- Headaches
- Migraines
- Dizziness
- Vertigo
- Ringing in ears
- Earaches
- Poor hearing
- Facial pain/pressure
- Sinus problems
- Environmental allergies
- Post-nasal drip
- Nose bleeds
- Jaw pain/clicks/locks
- Grinding/clenching teeth
- Dental/gum problems
- Dry mouth
- Peculiar tastes/smells
- Sores on lips/tongue
- Recurrent sore throat/colds
- Difficulty swallowing

RESPIRATORY

- Cough/wheezing
- Asthma
- Bronchitis
- Pneumonia
- Pleurisy
- COPD
- Emphysema
- Pain with deep inhalation
- Tight sensation in chest
- Coughing up blood
- Coughing up phlegm
  What color? _____
- Exposure to smoke/fumes
- Difficulty breathing when
  laying down
- Difficulty breathing with
  exertion

CARDIOVASCULAR

- Chest pain
- Chest pressure
- Irregular heart beat
- Palpitations at rest
- High blood pressure
- Low blood pressure
- Fainting
- Cold hands/feet
- Swelling of hands/feet
- Blood clots
- Varicose/Spider veins
- Phlebitis

GASTROINTESTINAL

- Poor appetite
- Heavy appetite
- Significant thirst
- Preference for hot/cold drinks
- Bad breath
- GERD/acid reflux
- Indigestion
- Belching
- Nausea
- Vomiting
- Food cravings _____
- Food intolerances _____
  _____
- Hiatal hernia
- Bloating/edema
- Abdominal pain/cramping
- Irritable bowel
- Crohn's/Colitis
- Diarrhea
- Constipation
- # of bowel movements per day?
  _____
- Loose stools
- Explosive/urgent stools
- Burning stools
- Dry/hard stools
- Gas
- Chronic laxative use
- Black stool
- Blood in stool
- Mucous in stool
- Hemorrhoids
- Rectal pain

GENITO-URINARY

- Frequent urination
- Urgent urination
- Unable to hold urine
- Pain on urination
- Burning on urination
- Blood in urine
- Cloudy urine
- Difficulty forming stream
- Dribbling after urination
- Copious flow
- Scanty flow
- Kidney stones
- Urinary tract infection
- Genital sores
- Herpes
- Excessive libido
- Low libido

- Nighttime urination… What time? _____ How often? _____

FOR MEN ONLY

- o Impotence
- o Premature ejaculation
- o Nocturnal emission
- o Pain in testicles
- o Prostatitis

FOR WOMEN ONLY

- o Difficult/painful intercourse
- o Vaginal dryness
- o Vaginal sores
- o Vaginal discharge
- o Infertility
- o Irregular periods
- o Painful periods
- o Heavy periods
- o Scanty periods
- o Clots in menses
- o Period stops and starts
- o Bleeding between periods
- o Ovarian cysts
- o Endometriosis
- o Polycystic Ovarian Syndrome
- o Pelvic Inflammatory Disease
- o Uterine fibroids
- o Painful breasts
- o Fibrocystic breasts
- o Post-menopausal
- o Menopausal symptoms _____
  _____
  _____
  _____
- o PMS symptoms _____
  _____
  _____
  _____
  _____

- o Age at first period? _____
- o First day of your last period? _____
- o Average number of days between periods? _____
- o Average number of days of bleeding? _____
- o Date of last PAP/Pelvic exam? _____
- o Number of pregnancies? _____
- o Number of live births? _____
- o Do you currently use birth control? YES/NO

MUSCULOSKELETAL

- o Muscle pain
- o Muscle weakness/fatigue
- o Muscle spasms
- o Muscle stiffness
- o Sprains/strains
- o Tendonitis
- o Bursitis
- o Neck pain
- o Shoulder pain
- o Rotator cuff injury
- o Arm/elbow pain
- o Hand/wrist pain
- o Carpal tunnel syndrome
- o Sciatica
- o Hip pain
- o Knee pain
- o Leg pain
- o Foot/ankle pain

- o Back pain… Upper? _____ Middle? _____ Lower? _____

- o General soreness/weakness in the lower body (back, hips, knees, ankles, feet)

NEUROPSYCHOLOGICAL

- o Nerve pain
- o Numbness
- o Seizures
- o Poor balance/falling
- o Lack of coordination
- o Poor memory
- o Difficulty concentrating
- o Concussion
- o Depression
- o Nervousness
- o Anxiety/panic attacks
- o Restless/jittery
- o Difficulty sleeping
- o Busy dreaming
- o Bad temper/irritable
- o Easily susceptible to stress
- o Seasonal Affective Disorder
- o ADD/ADHD
- o Bipolar disorder
- o OCD
- o PTSD
- o Other _____
  _____

COMMENTS

Please inform me of any other issues you would like to discuss.

_____

_____

_____

_____

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PRIVACY CODE

The privacy of your personal information is important to the Kucan Chiropractic and Acupuncture Clinic. We are committed to the collection, storage, use and disclosure of this information in a responsible way.

Personal Information:
Personal information is information about an identifiable individual. Generally, the information we collect is limited to name, home contact information, gender and age. As part of your patient file, we retain your health history, health measurements and examination results, health conditions, assessment results and diagnosis, the health services provided to you or received by you, your prognosis and other opinions formed, compliance with treatment and the reasons for your discharge and discharge recommendations. We may also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent. The use, retention and destruction of your personal information complies with and/or exceeds all existing legislation and privacy protection protocols. These standards are set by our regulatory body, the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO) and the law.

Clinicians and Staff Members:
Clinicians and staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to use. They are trained in the appropriate use and protection of your information. These individuals include clinic reception staff and other regulated health professionals, who work in the building.

Disclosure of Personal Information:
Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinic will use and disclose information.

- to deliver safe and effective patient care
- to be able to contact you
- to communicate with your other health care providers, <u>if and when you give us expressed permission to do so</u>
- to complete and submit claims on your behalf to third party payers
- to comply with legal regulatory requirements under the Regulated Health Professions act and the Chinese Medicine Act.
- to process payments and collect unpaid accounts

Patient please initial here:

By signing the consent section of this form you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Contact Processes:
On occasion we may need to contact you regarding scheduling, cancellation or other issues related to your care. Please check the appropriate boxes below for the type of communication that you consent to and fill in the appropriate number or address for each selected option.

- ❒ Home phone _____
- ❒ Cell phone _____
- ❒ Work phone _____
- ❒ Mailing Address _____
- ❒ Email Address _____

ANY RESTRICTIONS? (please describe): _____

_____

I have reviewed the above information that explains how the clinic uses my personal information, I know that I may ask to see this Privacy Code at any time.

I agree that Allison Kucan Hahn and the Kucan Chiropractic and Acupuncture Clinic can collect, use and disclose my personal information as set out above.

_____ _____
Patient Name Witness Name

_____ _____
Patient Signature Witness Signature

_____
Date