

Patient Health Summary

Traditional Healing Centre

Patient Information			
First Name:		Last Name:	Middle Name:
Telephone (Home/Mobile):		Telephone (Business):	Sex: M / F / Other
Home/Street Address:		Apt #:	Date of Birth: (DD/MM/YY)
City:	Province:	Postal Code:	Marital Status:
Occupation:		Email:	
Family Contact Information		First name:	Last name:
Relationship to Patient:		Phone Number:	Mobile Number:
Emergency Contact information (If different individual from above)		First name:	Last Name:
Relationship to Patient:		Phone Number:	Mobile Number:
Family Doctor Name:			
Clinic Address:			
Clinic Phone:		Clinic Email:	
Past Medical History			
<i>Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.</i>			
Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment			
<i>Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.</i>			

Please circle any conditions you are experiencing (past and present):

Date of Last Update of Patient Health Summary:

General Symptoms

Headaches/migraines
Fever
Chills
Sweat
Memory loss
Dizziness/Light-headedness
Fainting
Stress/depression
Discoordination
Nervousness
Recent weight loss/gain
Numbness/pain in arms, legs

Respiratory

Wheezing
Chronic cough
Spitting up phlegm
Chest pain
Difficulty breathing

Muscle and Joint

Stiff neck
Backache
Swollen joints
Painful tailbone
Pain in shoulder
Hernia
Spinal curvature
Faulty posture
Arthritis
Foot trouble

Cardiovascular

High or low blood pressure
Previous stroke or TIA
High cholesterol

Swelling of ankles
Poor circulation
Stroke/heart attack
Irregular heartbeat
Shortness of breath
Pain over heart

Genitourinary System

Frequent/painful urination
Blood in urine/stool
Mucus in stool
Kidney infection/kidney stone
Bladder infection
Inability to control urine

Ears, Eyes, Nose, Throat

Hearing loss
Vision problems
Glaucoma
Ringing in ear(s)
Crossed eyes
Eye pain
Deafness
Earache
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma

Dental decay
Gum trouble
Frequent colds
Enlarged thyroid

Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

Skin

Skin conditions/rashes
Itching
Bruise easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy

Gastrointestinal

Poor appetite
Distress from greasy foods

Excessive hunger/thirst
Belching or gas
Nausea
Vomiting
Burning in stomach
Pain over stomach
Constipation/diarrhea
Colon trouble
Liver trouble/hepatitis
Gallbladder
Ulcers

Colitis
Hemorrhoids
Hypoglycemia
Hiatal hernia

Metallic taste

For Women Only

Cramps/backache
Previous miscarriage
Irregular cycle
Vaginal discharge
Lumps in breast
Menopausal symptoms

Pregnant
Painful menstruation
Excessive flow
Hot flashes
Hysterectomy

Have you had any of the following?

Appendicitis	Malaria	Chicken pox	Alcoholism	Osteoporosis
Diabetes	Venereal infection	Cold sores	Whooping cough	Cancer
Epilepsy	Multiple sclerosis	Anemia	Heart disease	Tuberculosis
Pneumonia	Measles	Goiter	Eczema	Mental illness
Mumps	Influenza	Gout	Polio	Pleurisy
Rheumatic fever	Arthritis	Rubella	Parkinson's	HIV/AIDS

Signature of Patient: _____ **or Substitute Decision-Maker:** _____

Date: _____ **Relationship to Patient:** _____