Momentum Healing Arts Centre
Move body. Move blood. Move energy. Move life.

dragonbone
HOLISTIC HEALING ARTS
Ancient Theory Modern Methods

☐ **DR. ASTRID TRIM** ☐ **DR. TARA BROWN** ☐ **DR. CALVIN CHEUNG**

1065 CANADIAN PLACE, UNIT #101
MISSISSAUGA, ON
L4W 0C2

PATIENT INFORMATION:

Name: Mr., Mrs., Miss, Ms., Dr._____

Address: _____

City:_____ Postal Code: _____

Phone number: Home: _____ Cell: _____

Bus: _____

Emergency contact name: _____ Phone: _____

Email Address _____

By providing my email address, I give consent to receive updates and information about Momentum Healing Arts Centre. Momentum Healing Arts Centre will never give out or sell any patient addresses.

Date of Birth: _____/ _____/ _____ Age: _____ Gender: _____
(mo.) (day) (yr.)

Occupation:_____

Marital Status: _____M _____S _____W _____D

Spouse's Name: _____ No. of children: _____

Were your referred to this clinic? _____ Yes _____ No

If yes, by whom?_____

If no, how did you hear about this clinic? _____

Is your pain a result of a car or work accident? _____ yes _____ no

If yes, when was the accident: _____

Family Physician: _____

Address: _____ Postal Code:_____

Phone number: _____ Fax #: _____

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GENERAL HEALTH HISTORY:

Please circle any conditions or symptoms presently causing you problems.
Please X those conditions or symptoms which have been a health concern in the past.

GENERAL SYMPTOMS
Blackouts
Headaches
Migraines
Fever, Sweats
Fainting
Dizziness
Weight Loss
Loss of Sleep due to pain
Convulsions
Numbness or Tingling in arms/legs
Anxiety
Feelings of extreme stress

MUSCLES & JOINTS
Neck pain or stiffness
Mid back pain or stiffness
Low back pain or stiffness
Swollen & painful joints
Foot pain or injury
Knee pain or injury
Shoulder pain or injury
Arm/Forearm pain or injury
Wrist pain or injury
Hand/finger pain or arthritis
Weakness or loss of strength
Diagnosis of arthritis:
What kind? _____

EYES, EARS, NOSE, THROAT
Blurry/double vision
Failing vision (one/both eyes)
Eye pain
Deafness/Hearing loss
Chronic earaches
Ringing/buzzing in one/both ears
Asthma
Frequent colds/flus
Sinus infection
Enlarged lymph glands
Enlarged thyroid
Abnormal thyroid function levels
Slurred Speech
Difficulty swallowing

RESPIRATORY
Chronic cough
Spitting up phlegm or blood
Chest pains
Shortness of breath

CARDIOVASCULAR
Varicose Veins
Swelling of the ankles
Angina
Bleeding disorder
High blood pressure
Low blood pressure
High cholesterol
Do you take medication for these?
Yes _____ No ____

SKIN
Rashes, eczema, itching
Bruising easily
Dryness
Do you have any **allergies**? Yes No
If so, to what ? _____
_____

FOR WOMEN ONLY
Painful menstruation
Excessive flow
Irregular cycle
Cramps or backaches
History of breast cancer in family?
Yes _____ No _____
Are you menopausal?
Peri _____ Present _____Post _____
Are you on a Birth control pill?
Yes No
Have you been diagnosed with osteoporosis (low bone density)?
Yes No

Number of pregnancies? _____
Number of children? _____

GASTROINTESTINAL
Poor appetite
Indigestion
Hiatus Hernia/Acid Reflux
Recurring Constipation
Chronic Diarrhea
Kidney Stones
Gall bladder problems
Irritable Bowel Syndrome
Colitis /Crohns disease
Celiac disease
Do you take medication for any of the above? Yes __ No __
If yes, what?
_____

GENERAL QUESTIONS:

Have you ever been in a car accident? Yes No
When? _____

Sleep Posture: circle all that apply:
back stomach side

Are you currently a smoker? Yes No
Are you an ex-smoker? Yes No

Do you take medication on a regular basis? Yes No
Please list your medications:

- For high blood pressure
- For high cholesterol
- For high/low thyroid
- Blood thinners
  _____
- Other medications:
  _____

What is your current level of pain?
x----------x
0 1 2 3 4 5 6 7 8 9 10

Please draw your pain on the figure: