māhāyā
Health Services

2 College St. Suite 105
Toronto, ON M5G 1K3
info@mahayahealth.com
www.mahayahealth.com
T: 647.435.0152 F: 647.435.0163

TCM/ACUPUNCTURE PATIENT INFORMATION FORM

This is a CONFIDENTIAL questionnaire to help me determine the best-individualized treatment plan for you. If you have any questions, please ask. Thank you, Francis Rock.

Personal Information

Name: _____ Date: _____ Referred by: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Contact Phone #: _____ Email: _____

Would you like to receive our newsletter? ☐Yes ☐No

Are you interested in information about one of our *other holistic health practitioners*? If so, which ones?
☐Osteopathic Practitioner ☐RMT ☐Acupuncturist ☐Psychotherapist ☐Holistic Nutritionist

How did you learn about Mahaya? ☐ Mahaya Website Booking
☐Google ☐Facebook ☐ Yelp ☐ Open Care ☐ Friend of Mahya ☐Other _____

Occupation: _____ Sex: _____

Height: _____ Weight: _____ Birthdate: _____ Age: _____

Have you ever received Acupuncture before? ☐ Yes ☐ No
If yes - When? _____ With whom? _____

Have you ever taken Chinese Herbs before? ☐ Yes ☐ No
If yes - When? _____ With whom? _____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you have at present?

List any allergies, food sensitivities, or food cravings that you have?

List any accidents, surgeries, or hospitalizations (include date)?

māhāyā
Health Services

2 College St. Suite 105
Toronto, ON M5G 1K3
info@mahayahealth.com
www.mahayahealth.com
T: 647.435.0152 F: 647.435.0163

Please indicate any significant illnesses you or a blood relative (parent, sibling, grandparent) have had:

Illness	You	Your Relative	Illness	You	Your Relative
Cancer			Diabetes		
Hepatitis			Heart Disease		
High blood pressure			Seizures		
Rheumatic fever			Emotional Disorders		
Infectious Diseases			Tuberculosis		

List any medications and supplements you are currently taking: (Continue on back if necessary)

Medicine	Dosage	Reason	How Long	Prescribed by	Last Checkup

Please indicate the use and frequency of the following:

	Yes	No	How much?		Yes	No	How much?
Coffee/Black Tea				Tobacco			
Non-medicinal Drugs				Alcohol			
Water				Soda Pop			

How do you FEEL about the following areas of your life?

māhāyā
Health Services

2 College St. Suite 105
Toronto, ON M5G 1K3
info@mahayahealth.com
www.mahayahealth.com
T: 647.435.0152 F: 647.435.0163

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments
Significant Other						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spirituality						

Symptom Survey Please indicate as follows:
No mark ( ) = never experienced, Check mark (√) = sometimes experience, plus sign (+) = frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ jaundice (Yellowish eyes or skin)
___ digestive problems,indigestion
___ pain or coldness in the genital area
___ difficult to stop bleeding
___ belching, burping
___ heartburn/reflux
___ shortness of breath
___ feeling of claustrophobia
___ difficulty in making plans or decisions
___ feeling the retention of food in the stomach
___ tendency to become obsessive in work, relationships
___ skin problems
___ dizziness
___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands and feet
___ ear ringing
___ nightmares
___ mentally restless
___ laughing for no apparent reason

___ abdominal pain
___ chest pain
___ urinary problems
___ cough
___ nasal problems
___ low back pain
___ constipation
___ knee problems
___ hemorrhoids
___ hair loss

___ eye problems
___ easily bruised
___ sciatic pain
___ headaches
___ black tarry stools
___ difficulty digesting oily foods
___ gall stones
___ light colored stool
___ soft brittle nails
___ tendency to catch colds easily
___ easily angered or agitated
___ intolerance to weather changes
___ decreased sense of smell
___ spasms or twitching of muscles
___ bronchitis
___ tendency to faint easily
___ high cholesterol levels
___ hearing impairment
___ sudden weight loss
___ colitis or diverticulitits
___ kidney stones
___ decreased sex drive
___ recent use of antibiotics

___ fatigue
___ edema
___ blood in stool
___ vomiting
___ angina pains
___ asthma
___ allergies
___ hay fever

māhāyā
Health Services

2 College St. Suite 105
Toronto, ON M5G 1K3
info@mahayahealth.com
www.mahayahealth.com
T: 647.435.0152 F: 647.435.0163

FOR FEMALES

Age of first period (menarche): Are you pregnant? ☐ Yes ☐ No

Age of last period (menopause): # pregnancies: # live births: # abortions: #miscarriages:

Number of days between periods: Date of last: Gyne exam _____ PAP _____

Number of days of flow: Mammogram _____ Bone Density Scan _____

Color of flow: Results: _____

Average number of pads you use per day: 1st day ____ 2nd ____ 3rd ____ 4th ____ +days ____

Clots? ☐ Yes ☐ No Color: _____

Pain? ☐ Yes ☐ No

Location of pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other

Nature of pain: (please indicate before, during, or after menses)

cramping	stabbing	burning	dull	consistent
_____	_____	_____	_____	_____

aching	bloating	intermittent	bearing down sensation
_____	_____	_____	_____

Other symptoms related to menses?

☐ Discharge ☐ Vaginal dryness ☐ Headache ☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen breasts ☐ Mood swings ☐ Ravenous appetite ☐ Poor appetite

☐ Increased libido ☐ Decreased libido ☐ Hot flashes ☐ Night sweats ☐ Insomnia