梁子超(脊醫)
Dr. Tim C. Leung
脊骨神經科醫生
Doctor of Chiropractic

請盡可能準確地填寫此表格。所有信息將被保密。
Please fill out this form as accurately as you can. All information will be kept confidential.

日期
Date _____
(日dd / 月mm / 年yyyy)

稱謂 Title: ○ 教授 Dr. ○ 先生 Mr. ○ 女士 Mrs. ○ 小姐 Ms.

姓名 Name: _____ / _____
姓氏 Last 名字 First

生日日期 Birth date: _____
(日dd / 月mm / 年yyyy)

香港身分證號碼 HKID Card No. _____

住宅電話 Home phone _____

職業 Occupation _____

手提電話 Cell phone _____

住址 Address _____

公司電話 Work phone _____

電子郵箱 E-mail _____

介紹人 Referred by _____

今日來診的原因是 Reason for today's visit

_____

_____

你是否有被確診任何疾病？
Any diagnosed medical condition? _____

_____

你的家庭醫生姓名以及聯絡電話
Your Physician's name and phone number _____

您是否正在服用任何藥物？
Are you taking any medication?

_____

您是否正在服用維他命或營養補品？ (請列舉)
Are you taking any vitamins or nutritional supplements? (Please list) _____

_____

醫療記錄
Medical History

您有曾經使用以下用品嗎? 如有，多久一次？Do you use the following? If so, how often?

香煙 Cigarettes:_____酒精飲品 Alcohol: _____藥物 Drugs:_____

您對甚麼有過敏嗎?

Do you have any allergies? ◯ 有 Yes ◯ 沒有 No

請說明 Explain _____

_____

您是否曾因任何嚴重/傳染疾病住院？

Have you been hospitalized for any serious/infectious conditions? ◯ 有 Yes ◯ 沒有 No

如有，請簡單說明原因。 If yes, briefly describe the reason.

_____

請以下方格內加上「✓」號，表明以下哪種健康狀況適用於您？

Please indicate which, if any of the following health conditions apply to you by marking the boxes provided.

☐ 心臟疾病 Heart Condition	☐ 頭痛 Headaches	☐ 肝炎 Hepatitis
☐ 中風 Stroke	☐ 關節炎 Arthritis	☐ 愛滋病 AIDS
☐ 高/低血壓 High/Low Blood Pressure	☐ 頭暈/昏厥 Dizziness/Fainting	☐ 扭傷/骨折 Sprain/Fracture
☐ 深靜脈血栓形成 Deep Vein Thrombosis	☐ 消化系統疾病 Digestive Disorder	☐ 骨質疏鬆症 Osteoporosis
☐ 糖尿病 Diabetes	☐ 呼吸道疾病 Respiratory Disorder	☐ 傳染病 Contagious Illness
☐ 脊骨/頭部受傷 Spinal/Head Injury	☐ 腎病 Kidney Disorder	☐ 皮膚病 Skin Condition
☐ 神經疾病 Neurological Condition	☐ 癌症 Cancer	☐ 顳顎關節痛 Jaw Pain

您多久參加一次體育活動？

How often do you participate in physical activities?)_____

請以下任何對您適用的項目圓圈加上「✓」號

Please check if any of the following apply to you

◯ 血友病 Haemophiliac	◯ 懷孕或可能懷孕 Pregnant or may be	◯ 服用抗凝血劑 Taking Anticoagulants
◯ 需佩戴起搏器 Wear a Pacemaker	◯ 素食主義者 Vegetarian	◯ 手術 Surgery
◯ 癲癇 Epilepsy	◯ 嚴重的心臟或肺部疾病 Serious Heart or Lung condition	

如果您目前正在經歷這些症狀，或者過去幾個月來一直在經歷，請在相應的圓圈內加上「✓」號。
If you are currently experiencing these symptoms, or have been in the past few months, please check the appropriate circle.

腸胃 Gastrointestinal

- ○ 噁心 Nausea
- ○ 嘔吐 Vomiting
- ○ 胃酸倒流/胃灼熱 Acid reflux/Heartburn
- ○ 胃氣 Gas
- ○ 腹脹 Bloating
- ○ 打嗝 Hiccup
- ○ 糞便稀 Loose/Soft Stool
- ○ 口臭 Bad Breath
- ○ 便秘 Constipated
- ○ 交替腹瀉便秘 Alternate Loose/Constip.
- ○ 服用瀉藥 Laxative use
- ○ 黑便 Black Stools
- ○ 血便 Bloody Stools
- ○ 糞便中有粘液 Mucous in Stool
- ○ 腸痛/痙攣 Intestinal pain/cramps
- ○ 肛門灼熱/發癢 Burning/Itchy anus
- ○ 直腸疼痛 Rectal pain
- ○ 肛裂 Anal Fissures

呼吸 Respiratory

- ○ 慢性咳嗽 Chronic Cough
- ○ 咳血 Coughing up Blood
- ○ 咳痰 Coughing up Phlegm
  痰的顏色 Color of Phlegm _____
- ○ 呼吸困難 Difficulty breathing
- ○ 呼吸短促 Short Breath
- ○ 喘息/哮喘 Wheezing/Asthma
- ○ 經常感冒 Frequent Colds
- ○ 其他 Other _____

心臟 Cardio Vascular

- ○ 心悸 Heart Palpitations
- ○ 心跳快速 Rapid Heartbeat
- ○ 胸痛/胸悶 Chest pain/tightness
- ○ 心律不規則 Irregular Heartbeat
- ○ 血液循環差 Poor Circulation
- ○ 腳踝腫脹 Swelling of Ankles
- ○ 其他 Other _____

頭頸 Head & Neck

- ○ 頭暈 Dizziness
- ○ 昏厥 Fainting
- ○ 頸部僵硬 Neck Stiffness
- ○ 淋巴結腫大 Enlarged Lymph Nodes
- ○ 頭痛/偏頭痛 Headaches/Migraines
- ○ 其他 Other _____

生殖泌尿 Genito-Urinary

- ○ 生殖器官疼痛/痕癢 Pain/Itching Genitalia
- ○ 生殖器官損傷/分泌異常
  Genital Lesions/Discharge
- ○ 排尿疼痛 Painful Urination
- ○ 尿頻 Frequent Urination
- ○ 尿液過多或不足 Excessive or Scanty Urine
- ○ 尿液有血 Blood in Urine
- ○ 尿急 Urgent Urination
- ○ 無法存尿 Unable to Hold Urine
- ○ 夜尿 Wake to Urinate
- ○ 尿床 Bedwetting
- ○ 腎結石 Kidney Stone
- ○ 性慾增加 Increased Libido
- ○ 性慾減退 Decreased Libido
- ○ 其他 Other _____

口鼻喉 Nose, Throat & Mouth

- ○ 牙齦出血 Bleeding Gums
- ○ 鼻竇感染 Sinus Infection
- ○ 花粉過敏 Hay Fever
- ○ 反覆喉嚨痛 Recurring Sore Throat
- ○ 吞嚥困難 Difficulty Swallowing
- ○ 喉嚨有腫塊 Lump in Throat
- ○ 口苦 Bitter Taste in Mouth
- ○ 口腔潰瘍/飛滋 Canker Sores/Ulcers
- ○ 流鼻血 Nose Bleeds
- ○ 口乾/喉嚨乾 Dry Mouth/Throat
- ○ 喜歡熱飲 Prefer Warm Drinks
- ○ 喜歡凍飲 Prefer Cold Drinks
- ○ 其他 Other _____

眼睛 Eyes

- ○ 視野模糊 Blurred Vision
- ○ 飛蚊症 Spots/Floaters
- ○ 眼痛 Eye Pain
- ○ 眼乾 Dry Eyes
- ○ 夜視力差 Poor Night Vision
- ○ 眼睛紅腫/痕癢 Red/Burning Itchy Eyes
- ○ 其他 Other _____

耳 Ears

- ○ 反覆感染 Recurring Infection
- ○ 耳痛 Earaches
- ○ 耳鳴 Ringing Tone:
  ○ 高音 High Pitch ○ 低音 Low Pitch
- ○ 聽力下降 Decreased Hearing
- ○ 其他 Other _____

皮膚 Skin

- ○ 皮疹 Rashes
- ○ 濕疹/牛皮癬 Eczema/Psoriasis
- ○ 痕癢 Itch
- ○ 睡覺時冒冷汗 Night Sweats
- ○ 多汗 Spontaneous Sweats
- ○ 乾燥 Dryness
- ○ 潮熱 Hot Flashes
- ○ 其他 Other _____

胃口 Appetite

- ○ 健康/正常 Healthy/Normal
- ○ 需要經常吃 Need to Eat Often
- ○ 經常感到飢餓 Uncontrolled Hunger
- ○ 沒有胃口 Poor Appetite

睡眠 Sleep

- ○ 失眠 Insomnia
- ○ 容易醒/早醒 Wake Easily/Early
- ○ 睡眠淺 Light Sleep
- ○ 夢景鮮明 Vivid Dreams
- ○ 多夢 Dream Disturbed
- ○ 難以入睡 Difficult Falling Asleep
- ○ 每晚入睡時數
  Hours Per Night _____
- ○ 其他 Other _____

肌胳 Musculoskeletal

- ○ 背痛 Backache
- ○ 膝蓋疼痛 Knee Pain
- ○ 脊椎側彎 Spinal Curvature
- ○ 身體疼痛/僵硬 Body Aches/Stiffness
- ○ 身體沉重 Body Heaviness
- ○ 行走困難 Difficulty Walking
- ○ 關節痛 Joint Pain
- ○ 刺痛/發麻 Tingling/Numbness
- ○ 虛弱 Weakness
- ○ 其他 Other _____

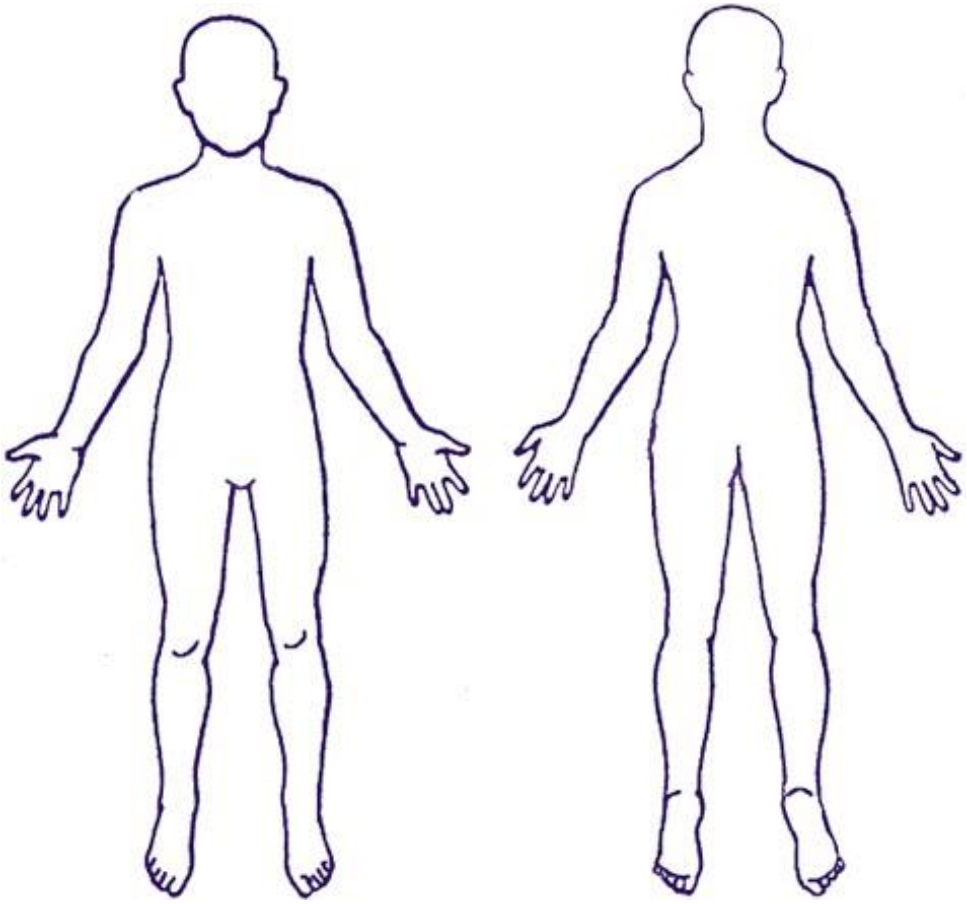
一般 General

- ○ 手腳冰冷 Cold Hands/Feet
- ○ 怕熱 Aversion to Heat
- ○ 怕冷 Aversion to Cold
- ○ 發燒/發冷 Fever/Chills
- ○ 疲勞 Fatigue
- ○ 其他 Other _____

情緒Emotions

○ 焦慮 Anxiety ○ 抑鬱 Depression ○ 憤怒/沮喪 Anger/Frustration ○ 憂愁 Sad ○ 善忘 Forgetful ○ 壓力大 Stressed

請在下圖圈出令您疼痛或關注的區域：
On the figure below please circle the areas of pain or concern:



前Front　　後Back

感覺/疼痛特徵，請在符合您的疼痛感覺之方格內打上「✓」號:
Sensations/Pain characteristics, please check next to sensations you are experiencing:

☐ 銳痛 Sharp	☐ 燃燒 Burning	☐ 移動 Moving	☐ 刺痛 Tingling	☐ 抽痛 Throbbing
☐ 刀刺 Stabbing	☐ 擊痛 Shooting	☐ 劇痛 Severe	☐ 酸痛 Dull	☐ 發麻 Numbness

甚麼有助您緩解疼痛(如有)（冰塊，休息，運動，按摩，加熱...）？
What, if anything, relieves the pain (ice, rest, activity, massage, heat...)?

甚麼加劇了疼痛（天氣，高溫，寒冷，休息，活動...）？
What aggravates the pain (weather, heat, cold, rest, activity...)?

您最近有受傷或發生意外嗎？
Do you have any injury or accident recently?

脊骨神經科治療同意書
INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

我謹此要求並同意由 BACK2LIFE HK CHIROPRACTIC 僱用的醫生對我（或以下所述之病人）進行脊科矯正和其他脊科治療方法，包括各種手療醫學治療和X光檢查。

我明白 BACK2LIFE HK CHIROPRACTIC 由註冊醫生經營，而我將由註冊醫生直接進行檢查和治療，或會在註冊醫生的監督下，由脊科助手進行治療。

我明白，藥物或脊科治療存有一定的風險，這包括但不限於骨折、椎間盤損傷、中風、移位和扭傷。我理解醫生不能夠預料並消除所有風險和複雜性，我相信醫生會根據當時的治療過程、感覺和事實情況，對我的利益做出最佳判斷。

我已經閱讀或已有人向我解釋上面的同意書。以下簽名表示我同意上面提到的要點。我明白本同意書能涵蓋我整個治療過程，包括目前的治療狀況以及我未來尋求治療的任何狀況。

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below) by the doctors of chiropractic employed by BACK2LIFE HK CHIROPRACTIC.

I understand that BACK2LIFE HK CHIROPRACTIC is operated by the licensed doctor, and that I will be examined and treated by a licensed doctor or treated by a chiropractic assistant under the supervision of a licensed doctor.

I understand that, as in the practice of medicine, in the practice off chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to reply on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts they known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

病人姓名 Patient's Name
(請打印 Please print)

日期 Date

_____

病人簽署 Signature of Patient
(或為18歲或以下病人之監護人 Or guardian if patient is a minor)