Acupuncture & Traditional Chinese Medicine Confidential Health History Form

Date: _____

Name: _____ Date of Birth: _(mm/dd/yr)_ Gender: M◯ F◯

Address: _____ Email: _____

Phone: H: _____ W: _____ C: _____

Occupation: _____ May we contact you by email? Y◯ N◯

Height: _____ Weight: _____

Emergency Contact: Name _____ Phone number _____

Medical Doctor: Name _____ Phone number _____

Health Goals / Concerns

What main health goal / concern led to you booking an appointment today?

How long have you had it:

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition:

Please list previous practitioners consulted for this condition (i.e. family doctor, physiotherapist etc):

Please describe their diagnosis, therapy and results where applicable:

What other types of therapy have you tried for this issue?

What makes it better?

What makes it worse?

Please list any other health concerns or goals in order of importance:

Medical History

Medical Conditions: *(please list any past or current medical conditions, hospitalizations, surgeries, injuries etc, with dates)*

Please list all medications and supplements you take on a regular basis, including length of use, dosage if known and the prescribing practitioner:

Allergies and / or food sensitivities:

Family History - *has anyone in your family been diagnosed with the following?*

Alcoholism ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chronic Fatigue ☐

Depression ☐ Diabetes ☐ Drug Abuse ☐ Eczema ☐ Epilepsy ☐ Fibromyalgia ☐

Heart Disease ☐ High Cholesterol ☐ High Blood Pressure ☐ Kidney Disease ☐

Mental Illness ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Osteoporosis ☐

Stroke ☐ Thyroid Disorder ☐ Other:

Pain & Tension

Please describe any pain or tension in your body *(incl. location, how long you have had it)*:

Diet & Digestion

Appetite: High ☐ Normal ☐ Low ☐

What kind of foods / meals do you typically eat?

Describe your thirst: Often thirsty ☐ Normal ☐ Rarely Thirsty ☐

Do you drink, smoke or use: Soda ☐ Coffee ☐ Alcohol ☐ Cigarettes ☐ Recreational Drugs ☐

How are your bowel movements?

Do you experience:

Constipation ☐ Diarrhea ☐ Dry Stools ☐ Loose Stools ☐ Straining ☐

Do you experience:

Gas ☐ Bloating ☐ Bad Breath ☐ Hiccups ☐ Acid Reflux ☐ Burping ☐

Stomach Pain ☐ Nausea ☐ Vomiting ☐ Indigestion ☐

Urination

Do you experience:

Very Frequent Urination ☐ Profuse Urination ☐ Scanty Urination ☐ Interrupted Flow ☐

Incontinence ☐ Urgency ☐ Blood in the Urine ☐ Cloudy Urine ☐ Pain while Urinating ☐

Difficulty Urinating ☐

Do you wake up at night to urinate? If so, how many times per night: 1 2 3 4 5+

Energy & Sleep

How would you rate your general energy level on a scale of 1 to 10? (1 very low - 10 very high): 1 2 3 4 5 6 7 8 9 10

Do you have difficulty falling asleep? Y ◯ N ◯

Do you wake up in the night? Y N If so, what wakes you? _____

Do you feel rested in the morning? Y N

Any other comments about your sleep or energy:

Head, Chest & Breathing

Do you experience any of the following?

Asthma / Wheezing Shortness of Breath Difficulty breathing Sinus Problems

Vertigo / dizziness Palpitations Phlegm Chest Tightness Chest Discomfort

Any other comments: _____

Skin & Sweat

Do you experience any of the following?

Acne or Boils Rashes Dry Skin Eczema Easily Bruised Varicose Veins

Sweat Easily Sweat Spontaneously Sweat Profusely Lack of Sweat

Sweat at Night Other comments: _____

Temperature

Do you tend to feel more hot or cold? Hot Cold Neither

Do you experience any of the following?

Cold Hands Cold Feet Hot Hands Hot Feet Fever Chills

Alternating fever and chills Aversion to heat Aversion to cold

Aversion to wind Other comments: _____

Emotional and Mental

How would you describe your outlook on life lately?

Do any of the following feelings occur more frequently?

Anger	Frustration	Anxiety	Sadness	Joy	Worry	Fear	Depression
☐	☐	☐	☐	☐	☐	☐	☐

Vision & Hearing

Do you experience any of the following visual symptoms:

Blurry vision ☐ Poor night vision ☐ Dry Eyes ☐ Red Eyes ☐ Itchy Eyes ☐

Watery Eyes ☐ Other comments: _____

For Women:

Age at first period:

Number of pregnancies: Number of children:

Is your menstrual cycle regular? Y N Average length of entire menstrual cycle: ___

How many days does your period last: ____ Please describe the flow: Heavy ◯ Light ◯ Normal ◯

What colour is the flow?

Bright red ☐ Pale red ☐ Dark red ☐ Purple ☐ Brown ☐

Are there clots? Y ◯ N ◯ If yes, what size are the clots? _____

Do you experience the following pre-menstrual symptoms?

Breast distention ☐ Breast tenderness ☐ Food Cravings ☐ Irritability ☐ Water retention ☐

Headaches ☐ Migraines ☐ Anxiety ☐ Depression ☐ Irritability ☐ Nausea ☐ Vomiting ☐

Diarrhea ☐ Constipation ☐ Abdominal cramps ☐

If you experience menstrual cramps, please describe:

Stabbing ☐ Aching ☐ Better with pressure ☐ Worse with pressure ☐ Better with heat ☐

Better with cold ☐ Better with exercise ☐ Worse with exercise ☐

Do you experience any of the following vaginal symptoms:

Vaginal dryness ☐ Vaginal pain ☐ Vaginal irritation ☐ Vaginal itching ☐

Bleeding between periods ☐ Profuse clear discharge ☐ Yellow smelly discharge ☐

Sexual Energy: High ◯ Low ◯ Normal ◯

Any other comments: _____

For Menopausal or Post Menopausal Women:

Age at last period:

Please describe symptoms related to menopause:

For Men:

How would you describe your sexual energy levels? Low ◯ Normal ◯ High ◯

Do you experience any of the following?

Swollen testes ☐ Impotence ☐ Genital coldness or numbness ☐

Testicular pain ☐ Premature ejaculation ☐ Spermatorrhea ☐

Other symptoms or comments: _____

Other:

Is there anything else that you feel is important that hasn't been addressed on this form?

Consents

Accuracy of Information

I am willing to provide my practitioner with the information necessary for them to fully understand my medical history, presenting symptoms and the health goals I wish to achieve. I thereby consent to a thorough case history and Traditional Chinese Medicine diagnosis. I understand that it is my responsibility to inform the practitioner of all current medications, herbs and supplements that I take. I will inform the practitioner of pregnancy, any pacemakers, artificial implants, addictions and allergies I have as they may affect the treatment plan.

I certify that the above medical information is correct to my knowledge:

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. I understand that clinical and administrative staff may review my patient records and lab reports. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I agree: ☐

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. For patients who provide less than 24 hours notice, or miss their appointment, the clinic reserves the right to charge a $45 missed appointment fee.

I am aware of the Cancellation Policy: ☐

Acupuncture Regulation Consent Form

Alberta's Acupuncture Regulations state that an acupuncturist shall not undertake the care and treatment of a person who has not consulted with a physician, or in the case of dental pathology, a dentist, about the condition for which he/she is seeking care and treatment.

Please select one option below:

I have already seen a doctor regarding the condition (s) that I am seeking treatment for ☐

I agree to see a doctor regarding the conditions (s) that I am seeking treatment for within 2 weeks of my first acupuncture treatment. ☐

Informed Consent for Acupuncture & Traditional Chinese Medicine

I understand that Traditional Chinese Medicine and Acupuncture can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that one method of treatment need not be chosen over others and that various methods often work best in conjunction with one another.

I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with acupuncture include, but are not limited to pain, bruising and fainting. I recognize that risks associated with cupping, moxibustion and gua sha (scraping) treatments include

but are not limited to minor burns, bruise-like marks, in addition to the associated risks of acupuncture.

I recognize that risks associated with taking Traditional Chinese Medicine herbal formulas prescribed to me by my practitioner could include but are not limited to side effects such as nausea, vomiting, diarrhea or rashes. I agree to notify the practitioner if I experience such side effects.

As with all forms of therapy, I understand that Traditional Chinese Medicine and Acupuncture also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect my practitioner to be able to anticipate and explain all risks and complications prior to treatment.

With this knowledge, I voluntarily consent to Traditional Chinese Medicine & Acupuncture treatments, and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.

I agree ☐

Full Name Date Signature

Acupuncture COVID-19 Prevention & Policy Consent

- I did not bring extra people to the appointment unless absolutely necessary.

- I and my companion(s) waited in the car and entered the clinic at the exact time of my appointment as possible.

- I and my companion(s) completed the screening questionnaire before entering the clinic.

- I and my companion(s) washed our hands with soap and water or hand sanitizer approved by Health Canada (https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/hand-sanitizer.html) immediately upon entering the clinic.

- I acknowledge that the Acupuncturist is performing an acupuncture treatment based on the COVID-19 prevention protocols and policies.

- I was informed of the risks associated with contraction of COVID-19 despite the implementation of the COVID-19 prevention protocols and policies there is a risk.

- I can disclose the contact information in the event that a patient who has visited the clinic in the last 14 days and is now testing (or has tested) positive for COVID-19.

Date _____

Signature _____