

Surgeries:

Month / Year	Reason	Hospital

Other Hospitalizations:

Month / Year	Reason	Hospital

List your prescribed drugs, vitamins, supplements and herbs:

Drug, vitamin, supplement, herb	Strength	Frequency Taken

List any allergies

Allergen	Reaction You Had

Please indicate a "P", "C" or "F" if any of the following health conditions below apply to you:

P = Past C = Current F = Immediate Family History

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Respiratory Disorder | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Dizziness / Fainting |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Contagious Illness |
| <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Sprain / Strain / Fracture | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Spinal or Head Injury | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Digestive Problems |

Please check off any of the following that apply to you:

Haemophiliac	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wear a pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you a vegetarian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have a serious heart or lung condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have surgeries scheduled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you are taking anticoagulant medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant or is there a chance you may be pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

Sedentary (No exercise)
 Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
 Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
 Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)

Diet:

Are you on a diet? Yes No If yes, are you on a physician prescribed diet? Yes No
 # of meals you eat in an average day? _____
 Glasses water/day _____
 Is your salt intake High, Medium, or Low? _____
 Is your fat intake High, Medium, or Low? _____

Caffeine:

None Coffee Tea Cola
 # of cups/cans per day? _____

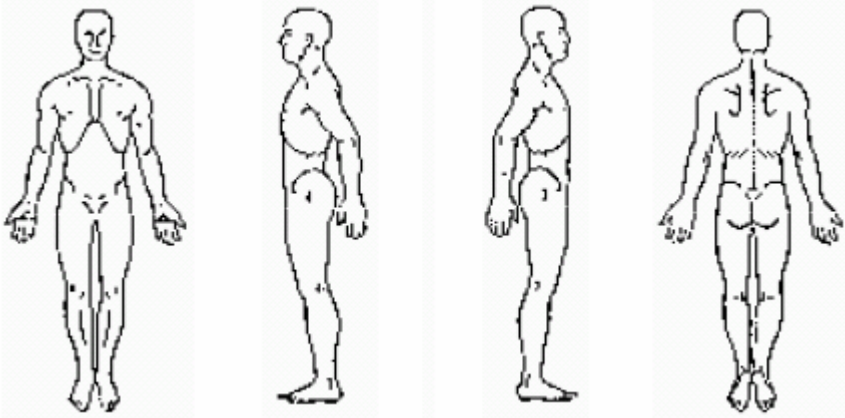
Alcohol:

Do you drink alcohol? Yes No If yes, what kind? _____
 How many drinks/week? _____

Tobacco:

Do you use tobacco?
 Cigarettes – pks./day Chew - #/day Pipe - #/day Cigars - #/day
 # of years Or year quit _____

On the figures below, please circle the areas of pain / concern:



Sensations / pain: Sharp Burning Moving Shooting
 Tingling Dull Severe Numbness

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____
 What aggravates the pain? (weather, heat, cold, etc.) _____

Other Symptoms/Problems:

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:

Head & Neck

Dizziness Fainting Neck Stiffness Enlarged Lymph Glands
 Headaches Migraines
 Other _____

Eyes

Blurred Vision Visual Changes Spots/ Floaters Eye Pain
 Dry Eyes Poor Night Vision Red/burning Itchy Eyes
 Other _____

Respiratory

Chronic Cough Coughing up Blood Coughing up Phlegm
 Difficulty Breathing Shortness of Breath Wheezing / Asthma
 Frequent Colds
 Other _____

Genital-Urinary

Pain/Itching of Genitalia Genital Lesions / Discharge Painful Urination
 Frequent Urination Excessive or Scanty Urination Blood in Urine
 Urgent Urination Unable to Hold Urine Wake up to Urinate
 Bedwetting Increased Libido Decreased Libido
 Kidney Stone
 Other _____

Cardiovascular

- Heart palpitations/rapid heartbeat Chest pain or tightness Poor Circulation
 Irregular Heart Beat Swelling of Ankles
 Other _____

Nose, Throat & Mouth

- Bleeding Gums Sinus Infection Hay Fever or Allergies
 Recurring Sore throat Swollen Glands Bitter taste in Mouth
 Difficulty Swallowing/Lump in throat Nosebleeds
 Tongue/Mouth Ulcers/Canker Sores Dry Mouth/Thirst
 Other _____

Muscles & Joints

- Joint Pain Body Aches/Stiffness Weakness Difficulty Walking
 Spinal Curvature Numbness/Tingling Bodily Heaviness Back ache
 Other _____

Ears

- Recurring Infection Earaches Ringing (High pitch Low pitch)
 Wax Build up Decreased Hearing
 Other _____

Skin

- Hives Rashes Hot Flashes Acne
 Night Sweats Dryness Eczema/Psoriasis Fine Hair/Falling out
 Bruise Easily Itching Easily/ Spontaneous Sweating
 Nails Breaking Easily/Flake Off Changes in Moles or Lumps
 Other _____

Gastrointestinal

- Nausea Vomiting Gas Rectal Pain
 Hiccup Bloating Bad Breath Loose/Soft Stools
 Constipated/Poor Elimination Anal Fissures Hemorrhoids Mucous in Stools
 Laxative Use Black Stools Bloody Stools
 Intestinal Pain or Cramping Itchy Anus Burning Anus
 Acid Reflux/Heartburn Alternate Loose/Constipation
 Other _____

Appetite

- Normal/Healthy Exceedingly Hungry Poor Appetite
 Need to Eat Several Meals Hungry, But No Desire to Eat
 Other _____

Sleep

- Sound/Restful Light Sleep Insomnia
 Heavy sleep Wake up Easily/Early Difficulty Falling Asleep
 Vivid Dreams/Nightmares Dream Disturbed
 Difficulty Waking Up # of Hrs of Sleep/Night _____
 Other _____

Emotions

- Relaxed / Calm Sad/Grief/Depressed Fearful Impatient
 Angry / Frustrated Forgetful / Poor Memory Anxious Stressed
 Other _____

General

- Cold Hands and Feet Cold Nose Aversion to Heat or Cold
 Feel Hot or Cold Fever and/or Chills Recent Changes in Weight
 Fatigue
 Other _____

Other comments:

MEN ONLY

Do you usually get up to urinate during the night? Yes No If yes, # of times _____
 Do you feel pain or burning with urination? Yes No
 Any blood in your urine? Yes No
 How long have you and your partner been trying to conceive? _____
 How would you define your sexual energy? Above Normal Below Normal Normal
 Date of last prostate and rectal exam _____
 Do you or did you have an undescended testicle? Yes No
 Have you ever been diagnosed with a varicocele? Yes No
 Have you ever had any urologic surgeries? Yes No
 Have you experienced erectile dysfunction? Yes No
 Have you experienced difficulty ejaculating? Yes No
 Have you had exposure to any known environmental toxins or hormones? Yes No
 Have you experienced any penile discharge? Yes No
 Do you regularly experience nocturnal emission? Yes No
 Do you have high cholesterol? Yes No
 Have you experienced a high fever in the last 6 months? Yes No
 Do you currently have any prostate conditions? Yes No
 Do you or have you ever had urinary infections or STD's? Yes No
 Have you ever taken testosterone supplements/drugs? Yes No
 Have you recently had your testosterone levels checked? Yes No
 Have you been diagnosed with small or soft testi? Yes No
 Have you been checked for a blockage of your reproductive tract? Yes No
 Have you had a fertility workup? Yes No
 If yes, What was your sperm count? Below Normal Normal Number: _____
 What was the sperm motility? Below Normal Normal Notes: _____
 What was the sperm morphology? Abnormal Normal Notes: _____

*Women: Please ensure that continue on to fill out the Women's Health Form as well

PATIENT INFORMATION & CONSENT FORM

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based up on the fact then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Cancellation Policy

In signing this form, I also understand and accept that a fee of \$60.00 (the full appointment fee) will be charged to your account if your cancellation or rescheduling is not done **24 hours** prior to the date of your appointment, and we are unable to fill that space.

Print name in full

(Print name of representative if represented by another)

Signature

(Signature of Representative)

Date