doctor FOR moms | perinatal & pediatric natural health center

TCM Patient Information

Date: _____

First Name: _____ Surname: _____ Middle Initial: _____

Date of Birth (M/D/Y):_____ Age: _____ Sex: M F

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation:_____ Marital Status:_____ Children:_____

CONTACT INFORMATION

	Number	Extension
Home:	_____	
Phone (bus):	_____	_____
Phone (cell):	_____	

Email Address: _____

REFFERAL INFORMATION

☐ Personal Referral: _____
☐ Doctor Referral: _____
☐ Physiotherapist: _____
☐ Midwife / Doula: _____
☐ Internet: _____
☐ Massage Therapist: _____
☐ Other: _____

CURRENT HEALTH CONDITION

Purpose of this Appointment: _____

Major Complaint: _____

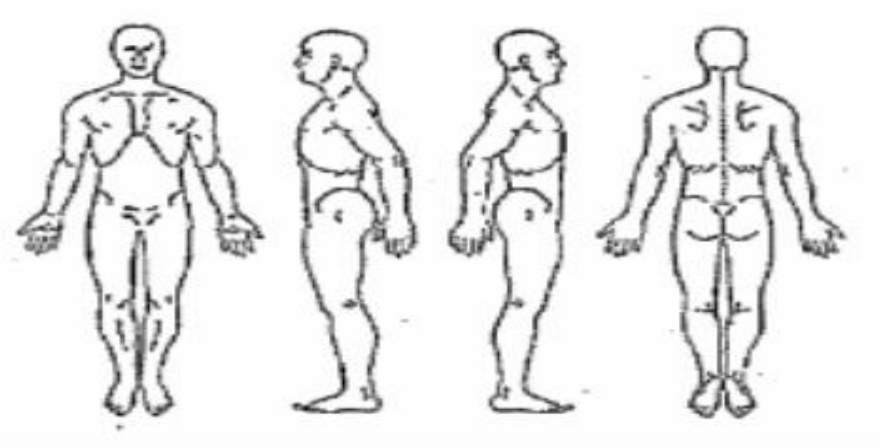
Have you had acupuncture before: _____

Medications/supplements/vitamins you are taking:_____

For what conditions: _____

Women: Are you pregnant? ☐ Yes ☐ No How many weeks? _____Due Date:_____

Please mark, with a circle, on the diagram below where you are experiencing any soreness or problems:



PAST HEALTH HISTORY

CHECK ANY DISEASE / ILLNESS YOU HAVE HAD:

☐ Rheumatic Fever	☐ Measles	☐ Pneumonia	☐ Fibromyalgia
☐ Diabetes	☐ Small Pox	☐ Mumps	☐ Chrohns
☐ Heart Disease	☐ Arthritis	☐ Chicken Pox	☐ Colitis
☐ A.I.D.S.	☐ Influenza	☐ Cancer _____	

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE and <u>UNDERLINE</u> THOSE YOU HAVE HAD IN THE PAST:

MUSCULO-SKELETAL
☐ Low back pain
☐ Pain between shoulders
☐ Neck pain
☐ Arm pain
☐ Joint pain/Stiffness
☐ difficult chewing/Clicking jaw
☐ General stiffness

CARDIO-VASCULAR
☐ Blood pressure problems
☐ Heart problems
☐ Lung problems/Congestion
☐ Stroke
☐ Chest pains
☐ Walking problems
☐ Varicose Veins
☐ Cold Hands and Feet

MALE/FEMALE
☐ Menstrual Irregularity
☐ Menstrual cramping
☐Vaginal pain/Infections
☐ Breast pain/Lumps
☐Miscarriage
☐ Difficulty Conceiving
☐ Endometriosis/ovarian cysts

RESPIRATORY
☐ Asthma
☐ Difficulty Breathing

NERVOUS SYSTEM
☐ Nervousness
☐ Numbness_____
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling extremities
☐ Stress

DIGESTIVE TRACT
☐ Nausea
☐ Heartburn
☐ Gas/Bloating after meals
☐ Constipation
☐ Diarrhea
☐ Bowel infections
☐ Weight issues

EYE/EAR/NOSE/THROAT
☐ Vision problems
☐ Sore throat
☐ Stuffed nose and sinuses
☐ Hearing difficulty
☐ Ear aches
☐ Ear infections

GENERAL
☐ Fatigue
☐ Loss of sleep
☐ Headaches
☐ Fever
☐ Poor appetite
☐ Allergies _____

GENITO-URINARY
☐ Bladder issues
☐ Painful Urination
☐ Excessive urination
☐ Yeast infections

EXERCISE (check one)
☐ none ☐ moderate ☐ daily
What? _____
_____
_____

FAMILY HISTORY (for example, Cancer/ Diabetes/Heart Problems/Back or Neck Pain)
Father: _____
Mother: _____
Brothers: _____
Sisters: _____

HABITS
☐ Caffeine: cups/day: _____
☐ Smoking: packs/day: _____
☐ Drinking: alcohol/wk: _____
☐ Fast Food: meals/wk: _____
☐ Junk Food: items/wk: _____
☐ Sleep: hours/night: _____
☐ Stress: low moderate high

DIET
☐ Poor
☐ Average
☐ Healthy (low fat, balanced meals)
☐ Organic
☐ Vegetarian
☐ Vegan

List all accident or falls: _____

Surgeries/ Operations: _____

Hospitalizations: _____

INFORMED CONSENT TO TREATMENT

Please Read Carefully.

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above-named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

Dated this _____ day of _____, 20___.

_____ _____
Patient Signature (Legal Guardian) Witness Signature

Name:_____ Name:_____
(Please Print) (Please Print)