



## Traditional Chinese Medicine

Welcome to DOWNTOWN INTEGRATIVE HEALTH GROUP and thank you for the opportunity to help you with your health. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly.

### PERSONAL INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City, Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_ Alberta Health Card Number \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (D/M/Y) \_\_\_\_\_ Age \_\_\_\_\_ Male [ ] Female [ ]

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Contact Person \_\_\_\_\_ Their phone number \_\_\_\_\_

Do you have extended health care benefits?  Yes  No With whom? \_\_\_\_\_

Is this a Workers Compensation Board injury?  Yes  No

Are your injuries related to a Motor Vehicle Accident?  Yes  No

**We appreciate those who refer their friends and family to our office. Please let us know who referred you to our care. Name**  
\_\_\_\_\_ Relationship to you \_\_\_\_\_

If you weren't referred, how did you hear about us?  M.D.  Website  Sign  Phone Book

Other \_\_\_\_\_

*\*Although our office does not direct bill third party insurance coverage, we do encourage our patients to check their benefit package regarding their coverage for the following services: chiropractic, naturopathy, TCM, acupuncture, massage therapy, orthotics, exercise therapy. We will issue you receipts that you can submit for reimbursement.*

### CURRENT HEALTH CONCERNS

*What are the most important health concerns for which you are seeking treatment from us or are receiving elsewhere?*

List in order of importance to you.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What do you hope to gain from your treatment here? Check all that apply:

Pain reduction  Return of function  Guidance for future prevention  Other: \_\_\_\_\_

**Health Providers** *Who else have you seen regarding your health and when was your last visit?*

- |   |  |
|---|--|
| <input type="checkbox"/> Chiropractor                             | <input type="checkbox"/> Naturopathic Doctor |
| <input type="checkbox"/> Medical Doctor                           | <input type="checkbox"/> Dentist             |
| <input type="checkbox"/> Physical Therapist                       | <input type="checkbox"/> Acupuncturist       |
| <input type="checkbox"/> Massage Therapist                        | <input type="checkbox"/> Homeopath           |
| <input type="checkbox"/> Traditional Chinese Medical Practitioner | <input type="checkbox"/> other               |

Last Visit \_\_\_\_\_ Name of your Medical Doctor: \_\_\_\_\_

Please list any prescription and non- prescription medications, vitamins and other supplements, the dosage and reason for using them.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

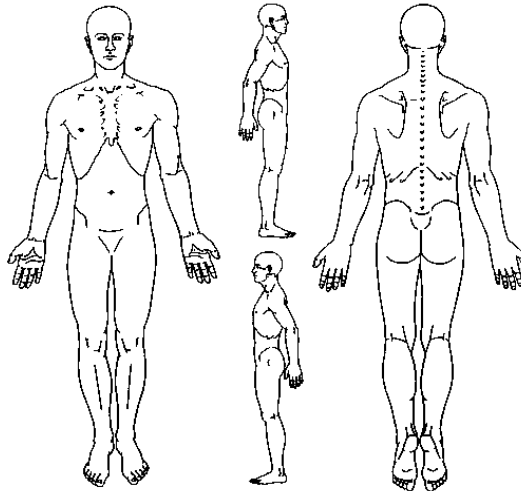
Please list any serious illnesses, surgeries, auto or sports injuries or broken bones  
\_\_\_\_\_ when \_\_\_\_\_

Have your reached full recovery? **Y N**  
\_\_\_\_\_ when \_\_\_\_\_

Have your reached full recovery? **Y N**  
\_\_\_\_\_ when \_\_\_\_\_

Have your reached full recovery? **Y N**  
\_\_\_\_\_ when \_\_\_\_\_

*On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.*



Use these letters to describe the pain: **S** sharp **D** dull **A** achy **H** hot **C** cold **N** numb **T** tingling **DB** deep and boring **TW** twisting **V** variable

How bad is the pain at its **LOWEST** and **HIGHEST** (no pain) 0-1-2-3-4-5-6-7-8-9-10 (worst pain ever)

When and how did it start? \_\_\_\_\_



## HEALTH LIFE STYLE INFORMATION

Your health is influenced by many factors. Your answers to the following questions are important and will be kept totally confidential.

Weight : \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_ Max weight: \_\_\_\_\_ Height : \_\_\_\_\_ Blood type:  
O A AB B  Don't know

Rate your energy level: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your quality of sleep: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your stress level: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Do you currently wear orthotics?  Yes  No Do you wear a dental splint?  Yes  No

What are your primary physical activities?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How would you describe your job?  physically demanding with heavy lifting  variety of sitting, standing and walking  mostly sitting  boring  satisfying  in transition

Do you smoke?  Yes  No How many per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Chew tobacco?  Yes  No How many per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Have you ever tried to stop?  Yes  No

Do you drink alcohol?  Yes  No How often?  daily  weekly  infrequently

Do you use recreational drugs?  Yes  No How often?  daily  weekly  infrequently

How often do you eat out per week?  less than 3  between 4 and 8  over 9

What would you say about your diet?  needs significant improvement  ok for now  very healthy

Do you drink coffee?  Yes  No How many cups/day? \_\_\_\_\_

Have you any diet preferences or restrictions?  vegetarian  celiac  other: \_\_\_\_\_

Please list any drug, food, and environmental allergies or sensitivities.

\_\_\_\_\_

Have you now or in the past had mercury dental fillings?  Yes  No  Yes, but they're removed

Have you any surgical implants or piercing (medical or cosmetic)?  Yes  No

Please be specific: \_\_\_\_\_

Have you been vaccinated?  Yes  No Any adverse reactions?  Yes  No

How many times have you been on antibiotics in the past two years? \_\_\_\_\_

Do you have a history of drug or alcohol abuse?  Yes  No



## REVIEW OF SYSTEMS

Please check the box if you are currently experiencing any of these symptoms.

- Mental/Emotional:**       Mood swings    Anxiety or nervousness    Poor concentration  
 Memory Problems    Depression    Anger
- Endocrine:**               Thyroid disease    Heat or Cold Intolerance    Diabetes                       Sugar  
Sensitivities    Fatigue    Weight loss/Weight gain
- Immune:**                  Chronic Infections    Chronic swollen glands    Slow wound healing  
 Frequent colds
- Skin:**                       Rashes    Eczema, Hives    Acne, Boils    Itching
- Head:**                      Headaches    Migraines    Head Injury
- Ears:**                      Earaches    Impaired Hearing    Dizziness    Ringing in Ears
- Nose and Sinuses:**     Nosebleeds    Seasonal Hay fever    Sinus problems    Loss of smell
- Mouth and Throat:**     Frequent sore throat    Sore tongue/lips    Tonsils removed  
 Change or loss of taste
- Respiratory:**             Cough    Wheezing    Asthma    Bronchitis    Emphysema  
 Chronic Phlegm    Pneumonia
- Cardiovascular:**         Heart disease    High/Low Blood Pressure    Palpitations  
 Arrhythmia    High Cholesterol    Cold extremities
- Gastrointestinal:**       Heartburn    Belching or Passing Gas    Change in thirst    Change in Appetite     
Constipation    Diarrhea
- How many bowel movements do you have per day? \_\_\_\_ Per week? \_\_\_\_
- Have you ever had parasites?    Yes    No    Don't know
- Have you ever had a colonoscopy?    Yes    No
- Genital-urinary:**         Difficulty with urination and/or frequent urination    Frequent night time urination  
 Incontinence    Discharge or sores    Chronic Infections
- Nervous System:**       Numbness/pain in extremities    Tingling in hands or feet    Paralysis
- Musculoskeletal:**      Joints:    pain/swelling/stiffness  
Muscles:    aches/cramps  
Spine:    recurrent neck or back pain    spreading pain to arms or legs

## FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

- Arthritis    Alzheimer's    Asthma    Cancer    Diabetes    Eczema    Heart Disease  
 Mental Illness    Multiple Sclerosis    Osteoporosis    Parkinson's    Thyroid Condition  
 Other \_\_\_\_\_

## WOMEN'S HEALTH

Is there a chance you could be pregnant?  **Yes**  **No**

Number of previous pregnancies \_\_\_\_\_ Number of miscarriages/abortions \_\_\_\_\_

Have you ever used birth control?  **Yes**  **No** What type? \_\_\_\_\_ How long? \_\_\_\_\_

How many days do you bleed? \_\_\_\_\_ How long between your periods (onset to onset)? \_\_\_\_\_

**Do you experience:**  Heavy flow  Light flow  Clotting  Bleeding between periods

Cramping  Pain during intercourse  Low sex drive

**Do you have pre-menstrual symptoms (PMS)?**  **Yes**  **No**

Pain or cramping  Mood Swings  Bloating and/or water retention  Headaches  Breast tenderness

Cravings  Other: \_\_\_\_\_

Have your periods stopped (menopause)?  **Yes**  **No** When? \_\_\_\_\_

Date of last bone density test \_\_\_\_\_  normal  osteopenia  osteoporosis

Date of last Pap test \_\_\_\_\_  normal  abnormal

Do you perform monthly self-breast exams?  **Yes**  **No**

When was your last professional breast exam? \_\_\_\_\_

Do you have regular mammograms?  **Yes**  **No**

## MEN'S HEALTH

**Do you have any of the following?**

Hernia  Testicular mass and or pain  Discharge or sores  Impotence or erectile dysfunction  Low sex drive  Prostate condition

Do you perform self-testicular exams?  **Yes**  **No**

Year of last prostate exam? \_\_\_\_\_

Are there any other significant events that you believe have impacted your health?

\_\_\_\_\_

## Informed Consent for Traditional Chinese Medicine (TCM) Diagnosis and Treatment

*This consent covers the following TCM treatment modalities:*

- Acupuncture (various forms)
- Cupping and Moxibustion
- Tui Na (Chinese medical massage, including acupressure)
- Herbal Therapy
- Medicated Diet and Nutritional Therapy
- Meditation and Breathing Techniques
- Qi Gong

I acknowledge that I have discussed, or have had the opportunity to discuss, the nature and purpose of TCM treatment(s) in general and my treatment(s) in particular, as well as the contents of this consent, with my Registered Acupuncturist and TCM Practitioner.

With regard to acupuncture, I have been advised that all needles are pre-sterilized and are disposed of after each use. I further understand and am informed that, as with all health care, the practices of acupuncture, cupping, moxibustion and tui na pose slight risks, which may include, but are not limited to: temporary bruising, soreness or sensitivity in the area(s) treated, swelling, blistering, bleeding, light-headedness or fainting, nausea, infection and shock.

I also understand that adverse reactions or interactions between recommended herbs, herbal formulas or foods with prescribed medications, supplements or natural health products, though rare, may occasionally occur.

I hereby consent to traditional Chinese medical diagnosis and treatment as described to me by my Registered Acupuncturist and TCM Practitioner. I intend this consent to apply to all my present and future TCM care.

\_\_\_\_\_  
Patient Signature                      Patient Name (Printed)                      Date

\_\_\_\_\_  
Witness Signature                      Witness Name (Printed)                      Date

I have read the following and understand that:

- I am responsible for my own health.
- It is my responsibility to inform the Registered Acupuncturist/TCM Practitioner of any medical conditions or allergies that I am aware of and any medications/supplements/herbs that I am currently taking.
- It is my responsibility to inform the Registered Acupuncturist/TCM Practitioner if I am pregnant, may be pregnant or am breast feeding.
- While changes in habits are not a pre-requisite for treatment, failure to follow the recommended dietary and/or lifestyle programs could undermine expected results. I understand that it takes time to feel better when using TCM. I accept that positive changes will occur more rapidly with increased compliance.
- It is my responsibility to clarify treatment issues with my Registered Acupuncturist/TCM Practitioner.
- I am free to discontinue treatment at any time.
- I accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered.

*Canceling or rescheduling appointments must be done 24 hours in advance and that I may be charged for missed appointments.*