Traditional Chinese Medicine & Acupuncture
General Information

Date: _____

Name (first):_____ (last):_____

Address:_____

Best number to reach you at? _____

Best email to contact you with? _____

Birth date (dd/mm/yyyy)_____/_____/_____ Sex: M / F

How did you hear about our clinic? _____

Reason for your appointment? _____

When did your condition begin? _____

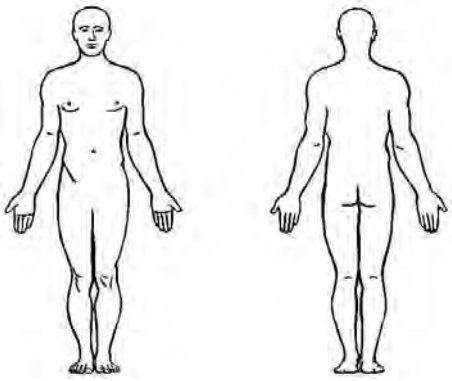
Do your symptoms prevent you from completing daily tasks? Yes No

Have you been treated by other health professionals with regard to this issue? Yes No

If yes, by whom? _____

Is your condition due to a car accident? Yes No Date of accident: _____

Do you have pain in any of the following areas? (circle all that apply)



Do you have any allergies?_____

Are you currently taking any medication? _____

_____

Do you have a cardiac pacemaker? Yes No

Have you had x-rays, MRI or other tests recently? What tests and when?

_____

_____

Family doctor name: _____ Ph#: _____
Emergency Contact: _____ Ph#: _____

Traditional Chinese Medicine & Acupuncture Intake Form cont.

If you are currently experiencing any of these symptoms, please check the appropriate circle.

LUNG

◯Allergies	◯Frontal/Sinus Headache	◯Asthma
◯Frequent Colds	◯Grief/Sadness	◯Constipation
◯Lethargy	◯Chronic Cough	◯Spontaneous Sweating
◯Eczema	◯Excess Mucous	◯Shortness of Breath

KIDNEY

◯Impotence	◯Tinnitus	◯Low Back Pain
◯Knee pain	◯Infertility	◯Freq Bladder Infections
◯Thinning hair	◯Fear	◯Night Sweating
◯Edema/swelling	◯Hot Flashing	◯Burning Urination

LIVER

◯Anger/Irritability	◯Migraines	◯PMS
◯Indigestion	◯Irritable Bowel Syndrome	◯Bloating
◯Vision Troubles	◯Dry Eyes	◯Tight Chest

HEART

◯Anemia	◯High Blood Pressure	◯Restlessness
◯Anxiety	◯Difficulty falling asleep	◯Difficulty Staying asleep
◯Dream Disturbed Sleep	◯Palpitations	◯Dizziness

SPLEEN

◯Abdominal Pain	◯Looser stools	◯Heavy Limbs
◯Weakness	◯Nausea/Vomit	◯Heavy Head
◯Poor Memory	◯Hemorrhoids	◯No appetite

◯Blood Clots	◯Shingles	◯Atherosclerosis
◯Heart Attacks	◯Hepatitis	◯HIV/AIDS
◯Stroke	◯Diabetes	◯Clotting Disorders

Please check preferences:

Do you prefer to drink: WARM/HOT FLUIDS COLD FLUIDS

Are you frequently thirsty? YES NO SOMETIMES

During the day do you usually feel: WARM COLD SWEATY

What best describes your emotional state: ANGRY ANXIOUS FEARFUL
SAD WORRIED SHOCKED JOYFUL

Traditional Chinese Medicine & Acupuncture
Women's Health Form

Age of your first menstrual period:_____ Duration of periods?____ days

Length of cycle _____ days. When was your last menstrual period?_____

Do you experience pain before, during or after your period? YES NO

How heavy is your bleeding? LIGHT NORMAL HEAVY

What color is your blood? LIGHT RED DARK RED PURPLE

Is there clotting? YES NO If yes, BIG SMALL

Do you bleed or spot in between periods? YES NO

Are you pregnant? YES NO If yes, how many weeks? _____

Endometriosis? YES NO Ovarian cysts/Fibroids? YES NO

Abnormal PAP smear? YES NO How many children do you have?_____

How many pregnancies?_____ How many abortions?_____ How many miscarriages?_____

Do you get yeast infections regularly? YES NO

Have you ever had a venereal disease? YES NO

Do you get premenstrual back pain? YES NO

Do your bowel movements become loose at the beginning of your period? YES NO

Please circle all those that apply to you, in relation to your menstruation:

Heavy flow	Light flow	Clotting	Vaginal discharge
Vaginal dryness	Vaginal itching	Vaginal odor	Pain during intercourse
Breast Tenderness	Painful periods	Cramping	Cravings
Headaches	Bloating	Water Retention	Irritability
Fatigue	Insomnia	Anxiety	Clumsiness

Have you had a hysterectomy? YES NO

FERTILITY

Birth control method: CONDOMS PILLS IUD DIAPHRAGM

Other:_____

Are you trying to get pregnant? YES NO

Traditional Chinese Medicine & Acupuncture
Explanation of Fees

The purpose of this page is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time.

Procedure	Consists of:	Fee:
Initial Visit	Consultation/Treatment	$89.25
Subsequent Visits	Treatment	$89.25
Chinese Herbs	As prescribed by doctor	Varies
Missed Appointments	24 hours required to cancel	Minimum $40
Cupping	Treatment addition	$45
Insurance Forms	As per request	Minimum $20

Forms of payment:

Patients are responsible for full payment at the time services are rendered. We accept Interact, Visa, Mastercard, cash or cheque. We reserve the right to charge a $15.00 NSF fee for all bounced cheques. Any credit arrangements must be authorized in advance.

Cancellation Policy:

If you cannot make your appointment please call the office to inform us at least 24 hours before your scheduled time so that another patient may be booked during that time. At the discretion of the practitioner, a minimum fee of $40 up to the total applicable appointment fee, as described above, may be charged for missed appointments or appointments cancelled within 24 hours of the scheduled time.

Third Party Insurance Coverage:

Many secondary health plans provide Acupuncture coverage. All professional services are rendered and charged to the patient receiving care and not to an insurance provider. We will supply you with receipts, statements, reports, or other documents for a fee, if applicable, as outlined above, to help you receive reimbursement from a third party.

I have read, understood, and agreed to the fees and payment obligations as listed above.

_____ _____

Patient/Parent/Guardian Signature Date

Traditional Chinese Medicine & Acupuncture
Progress Report

Date: _____

Please rate the following on a scale from 1 – 10, 1 being you experience very little, 10 being you experience to a great degree.

	NOT									YES
I fall asleep easily:	1	2	3	4	5	6	7	8	9	10
I sleep all night:	1	2	3	4	5	6	7	8	9	10
I have headaches:	1	2	3	4	5	6	7	8	9	10
I have stomach pains:	1	2	3	4	5	6	7	8	9	10
My bowels are regular: (once per day)	1	2	3	4	5	6	7	8	9	10
I have pain:	1	2	3	4	5	6	7	8	9	10
I am moody:	1	2	3	4	5	6	7	8	9	10
My energy level:	1	2	3	4	5	6	7	8	9	10
I drink water all day:	1	2	3	4	5	6	7	8	9	10
I have skin conditions:	1	2	3	4	5	6	7	8	9	10
I have menstrual pain:	1	2	3	4	5	6	7	8	9	10
I have stress:	1	2	3	4	5	6	7	8	9	10