Please fill out the following section of this form. With your detailed information, a more accurate diagnosis and identification of patterns will result. This will help the acupuncturist devise the proper treatment and schedule for you. Thank you for your cooperation!

Last Name	**First Name**	**Date of Birth** YYYY MM DD	**Age**
Address		**City and Province**	
Postal Code	**Sex** ( ) M ( ) F	**Marital Status**	
Home Phone No.	**Work Phone No.**	**Mobile No.**	
E-mail		**Occupation**	

What is your complaint? How long has it been?

What type of diagnosis/ treatment was given?

Current Medications Being Used

Life Style

Diet (good/ poor/ vegetarian) Exercise (times a week) Stress level (high/ normal/ low)
Smoking (times a day) Drinking (times a week)
Other (Please describe):

Medical Issues (Please circle)

Hepatitis Hypertension Tuberculosis Asthma Diabetes Kidney Problems Allergies
Heart Disease Arthritis Alcoholic HIV(+) Seizures Thyroid disease Mental/ Psychological disorders
Pregnancy Surgeries(Name of the surgeries :)
Other (Please describe):

For Women

Age of First Period ( ) Age of Menopause ( ) Date of Last Period ( )
Days between Periods (Regular/ Irregular: Days) Duration of the Period (Days)
Color of the Flow (Pale/ Normal / Dark/ Clots) Amount of the Flow (Light/ Medium/ Heavy)
PMS or Other Syndromes Related ( )
Vaginal Discharge (Yellow/ White/ Sticky/ Watery) Last Test (Date: Reason:)
No. of Pregnancy ( ) No. of Live Birth ( ) No. of Premature Birth ( )
Abortion / Miscarriage (No. Age:) Other ( )

Are you sexually active? **Yes ( ) No ( )**	**Date of Today** YYYY MM DD	**Your Signature**

Bayview Village Wellness Centre
Acupuncture/Traditional Chinese Medicine
Li Hua, Jin,. R.Ac.& R.TCMP

Li Hua Jin, Registered Acupuncturist & TCM Practitioner
INFORMED CONSENT for Acupuncture & Traditional Chinese Medicine Therapy

I hereby request and consent to the performance of acupuncture treatment and other procedures with the scope of Traditional Chinese Medicine (TCM) on me (or the patient named below, for whom I am legally responsible) by Li Hua Jin, and/or other Ontario Registered Acupuncturists who may treat me now or in the future while associated with or referred to herein as the Acupuncturist.

I understand the methods of treatment may include, but are not limited to acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, and nutrition counseling.

I have had the opportunity to discuss with the Acupuncturist named herein and/or with other office or clinical personnel, the nature and purpose of acupuncture and Traditional Chinese Medicine. I understand that the results are not guaranteed.

I understand that there is some minor risks attendant to acupuncture treatment, including, but not limited to some light bruising and/or blisters of the skin and/or slight bleeding. I understand that slight bruising, blisters are a common response to cupping and gua sha treatments. I will inform my Acupuncturist if I have any condition and/or taking medication that interferes with blood clotting. I will notify my Acupuncturist if I have a pace maker as electrical stimulation is contraindicated. I will notify my Acupuncturist should I become pregnant as certain acupuncture protocols are contraindicated (while other TCM treatments are favorable).
I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels, based on the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab records, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I acknowledge this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

About your treatment

1. Sometimes, after receiving an acupuncture treatment, you may feel a little bit light headed. If that happens, please sit for a while in the waiting room. In a few minutes you will feel fine.

2. Herbal prescriptions and herbal paten medicines are intended only for the person for whom they were dispensed.

Please sign and date below to indicate that you have read and understand this form.

_____ _____

Patient Signature (or Guardian, if minor) **Date**

_____

Printed Name