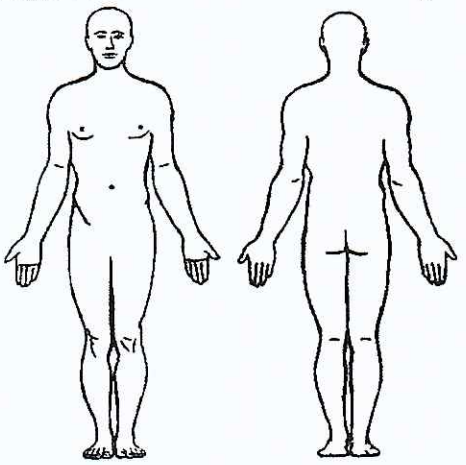
NAME:_____

Patient Questionnaire

On the figure below, please mark any areas (with a circle) where you feel pain or discomfort in your body. If the pain travels anywhere, please indicate this using arrows.

Right FRONT **Left** **Left** BACK **Right**



Please list complaints in order of severity:

1._____

2._____

3._____

4._____

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

- o Abdominal Problems
- o Dislocations
- o Numbness or Tingling
- o Arthritis Dizziness
- o Polio/Post-Polio Syndrome
- o Asthma
- o Fractures
- o Psychiatric or Psychological Care
- o Artificial Joint
- o Gastrointestinal Disorder
- o Recent Weight Loss or Gain
- o Balance Problems
- o High/Low Blood Pressure
- o Respiratory Condition
- o Blurred or Double Vision
- o Headaches
- o Seizures
- o Cancer /History of/Family History of
- o Heart Disease /Family History of
- o Shortness of Breath
- o Chest Pain
- o Herniated Disc
- o Skin Condition
- o Concussion
- o Hot or Cold Intolerance
- o Sleep Disorder
- o Currently Pregnant
- o Nausea/Vomiting
- o Stroke
- o Diabetes
- o Neurological Disorder
- o Ulcers
- o Difficulty Swallowing/Eating
- o Osteoporosis/Low Bone Density
- o Vascular Disease

Other:

Please list all surgeries and/or significant injuries/accidents (with approximate date):

_____

Please list all medications and/or supplements currently being taken:

_____

Are you currently a smoker? YES / NO
If yes, how many cigarettes per day: ____
Have you smoked in the past? YES / NO

Patient Informed Consent to Treatment
Te Chun Yu R1201047

I, or the person listed below, have discussed with my traditional Chinese medicine practitioner or acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, gua sha, and Tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
6. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

_____
Patient Signature

_____
Practitioner Signature

_____
Date

_____
Date