

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

Date of Birth (mm/dd/yy) \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Occupation \_\_\_\_\_

Phone (H) \_\_\_\_\_ E-mail \_\_\_\_\_

Phone (C) \_\_\_\_\_  Married  Single  Divorced  Widowed

Phone (W) \_\_\_\_\_ Spouse's name (if married) \_\_\_\_\_

Do you have extended health benefits for acupuncture?  Yes  No  Don't know \$ Participation/year? \_\_\_\_\_

*Emergency Contact/Next of Kin:*

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Major Complaint(s), in order of significance to you:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ Additional: \_\_\_\_\_

Medications you are currently taking:

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

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Supplements (vitamins, minerals, herbs, etc.) \_\_\_\_\_

On a scale of 1 to 10, please rate your commitment to improving your health (*circle number*):

1    2    3    4    5    6    7    8    9    10

← Not committed                      Somewhat committed                      Highly committed →

How did you hear about our office? \_\_\_\_\_

Have you ever received acupuncture before?  No  Yes

If yes, how often and for how long? \_\_\_\_\_

# Informed Consent to Acupuncture and Traditional Chinese Medicine Treatment

Avenue Acupuncture  
202-1896 Avenue Rd  
Toronto, ON, M5M 3Z8  
(416) 449-6756

I, the undersigned, understand that acupuncture and other Traditional Chinese Medicine modalities are safe and effective for the prevention and treatment of a wide range of health problems, and for the promotion of general well being. I understand that acupuncture is not a substitute for conventional medical diagnosis and treatment provided by a medical doctor. I am aware that the acupuncturist does not diagnose illnesses or diseases and does not prescribe medications. I am aware that if I want to alter my pharmaceutical regime in any way, I must consult my medical physician before doing so.

I have informed the acupuncturist of all my known physical, emotional, and medical conditions and medications, and I will keep the acupuncturist updated on any changes. If I experience any pain or discomfort during the session, I will immediately communicate that to the acupuncturist so the treatment can be modified.

I acknowledge that there are some risks to the treatment. These side effects may include, but are not limited to the following: Some pain following treatment in the insertion area, minor bruising, light-headedness, and fatigue.

I understand that there is neither an implied nor stated guarantee of success or effectiveness of a specific treatment or series of treatments. I understand that certain medications and social habits may decrease the beneficial effects of acupuncture Chinese herbs. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I agree to give 24 hours notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged at current clinical rates when no notice is given or for failing to show up to the appointment. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of present and future care.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# New Patient Health History Questionnaire

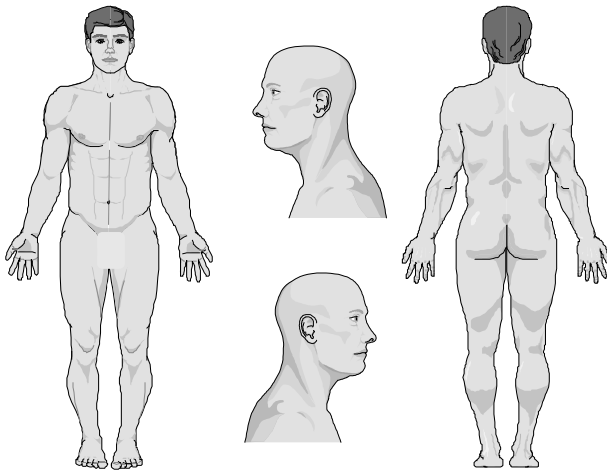
Please indicate if you have (or had) any of the following:			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Vein Condition
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Polio
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Migraines
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Other Liver Illnesses
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Fever	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other Heart Illnesses
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other Kidney Illnesses
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other Lung Illnesses

**SURGERIES?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**1. Describe your pain:**

On the figures below, please mark clearly any areas of pain.

- Sharp
- Fixed
- Burning
- Moving
- Cramping
- Aching
- Dull
- Other: \_\_\_\_\_



**2. Kidney Function:**  
*(Overall Temperature)*

- Cold Hands
- Cold Fingers
- Cold Toes
- Cold Feet
- Sweaty Hands
- Sweaty Feet
- Hot Body Temperature Sensation
- Cold Body Temperature Sensation
- Afternoon Flushes
- Night Sweats
- Heat in the hands, feet & chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed

**3. Lung Function:**

- Nasal Discharge (colour \_\_\_\_\_)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry Mouth
- Dry Throat
- Dry Nose
- Dry Skin
- Allergies (what? \_\_\_\_\_)
- Alternating Chills/Fever
- Sneezing
- Headache (location \_\_\_\_\_)
- Stiff Neck
- Sore Throat
- Difficulty breathing
- Smoke cigarettes (# per day \_\_\_\_\_)
- Sadness

# New Patient Health History Questionnaire

## 4. Lung, Kidney Function: (Overall Energy)

- Shortness of Breath
- Difficulty keeping eyes open (daytime)
- General Weakness
- Easily catch colds
- Low Energy
- Feel worse after exercise
- Chronic (daily) fatigue & malaise

## 5. Liver Function (eyes):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry Vision
- Decreased Night Vision
- Near-sighted
- Far-sighted
- See Floating Black Spots

## 6. Bladder Function

Colour (please check):

Pale\_\_\_\_; Dk Yellow\_\_\_\_; Clear\_\_\_\_

- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odour
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

## 7. Heart Function:

- Anxiety
- Sores on tip of tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Trouble falling asleep
- Wake frequently during night
- Wake early and cannot return to sleep
- Coffee? How much per week? \_\_\_\_\_
- Dizziness

## 8. Spleen Function:

- Low Appetite
- Abrupt Weight Gain
- Abrupt Weight Loss
- Abdominal Bloating
- Abdominal Gas
- Gurgling noise in Stomach
- Fatigue after eating
- Prolapsed Organ? Which? \_\_\_\_\_
- Bruise easily?
- Over-Thinking
- Worry

## 9. Spleen, Stomach, Small/Large Intestine Function

- Loose Stools
- Constipated
- Incomplete Stools
- Diarrhea
- Blood in Stools
- Mucous in Stools
- Undigested food in the Stools

## 10. Stomach Function:

- Burning sensation after eating
- Large appetite
- Bad Breath
- Canker Sores (mouth)
- Bleeding, swollen or painful gums
- Heartburn
- Acid Regurgitation
- Ulcer (diagnosed? Y N)
- Belching
- Hiccups
- Stomach Pain
- Vomiting

## 11. Water Retention

- Bodily sensation of heaviness
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring
- Overall achy feeling

# New Patient Health History Questionnaire

## 12. Kidney, Urinary Bladder Function:

- Frequent cavities, teeth problems
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones
- Bladder Infections
- Lack of bladder control
- Wake during the night (2 or more) times to urinate?
- Fear
- Easily startled
- Low libido

### Women Only:

For the following complaints, check off which applies to your menstrual cycle

	Pre	During	Post
<input type="checkbox"/> Nausea			
<input type="checkbox"/> Vomiting			
<input type="checkbox"/> Food cravings			
<input type="checkbox"/> Water retention			
<input type="checkbox"/> Breast swelling			
<input type="checkbox"/> Breast tenderness			
<input type="checkbox"/> Headaches			
<input type="checkbox"/> Migraines			
<input type="checkbox"/> Dull pain			
<input type="checkbox"/> Sharp pain			
<input type="checkbox"/> Depression			
<input type="checkbox"/> Irritability			
<input type="checkbox"/> Anxiety			
<input type="checkbox"/> Other (explain _____)			

## 13. Liver, Gall Bladder Function:

- Alternating Diarrhea & Constipation
- Chest Pain
- Tight sensation in the Chest
- Bitter taste in the mouth
- Anger easily
- Depression
- Frustration
- Irritability
- Skin rashes
- Headache at the top of the head
- Tingling sensation
- Numbness
- Muscle twitching
- Muscle cramping
- Muscle spasms
- Seizures
- Convulsions
- Lump in the throat
- Neck tension
- Shoulder tension
- Limited Range-of-Motion (Neck)
- Limited Range-of-Motion (Shoulder)
- Alcohol intake / week? \_\_\_\_\_
- Recreational drugs (which? \_\_\_\_\_)
- High-pitched Ringing in Ears
- Gallstones (history or current)
- STDs (which? \_\_\_\_\_)
- Unable to adapt to Stress
- High libido

### Men Only:

- Swollen testes
- Testicular pain
- Impotence
- Premature ejaculation
- Feeling of coldness or
- Numbness in external genitalia

WOMEN ONLY					
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a regular menstrual cycle?	_____	Age of first menstruation	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?	_____	Average number of days in flow	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have bleeding between periods?	_____	Average number of days in entire cycle	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have vaginal discharge?	_____	Number of children	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you using birth control pills?	_____	Number of pregnancies	_____
				Age of menopause (if applicable)	_____

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>Colour (choose one):</b> pale, bright red, brown rust, dark purple, other							
<b>Amount of flow (choose one):</b> light, medium, heavy							
<b>Clotting (choose one)</b> none, light red, dark red, purple							