WELCOME
Acupuncture & Herbs Wellness Clinic
CONFIDENTIAL PATIENT INFORMATION

PLEASE COMPLETE THIS QUESTIONNAIRE AS ACCURATELY AS POSSIBLE. THIS WILL HELP US TO DETERMINE YOUR TREATMENT.

Last Name: _____ First Name: _____

Sex: Male ( ) Female ( ) Age: _____ Birthday: ____(DD) ___(MM) ____(YY)

Occupation: _____

Address: _____
Postal code: _____

Phone: (Home) _____(Bus) _____(Cell) _____

E-mail (please print): _____

Is this a Worker's Compensation case? Yes ( ) No ( )

If Yes, what is your claim number for this injury? _____

Referred by: _____

Family Doctor: _____ Phone: _____

1. Please list your **main complaints**

1)_____ For how long? _____

2)_____ For how long? _____

3)_____ For how long? _____

Have you seen a physician for these problems? Y N

If yes, what diagnosis were you given? _____

What kind of treatment have you received? _____

2. Medical History

a) Are you presently under the care of a medical doctor, or any other kind of health care profession? Y N
If yes, please explain: _____

b) Briefly describe your health history. e.g. Surgeries, Illnesses, Fall unconscious, Major stresses, Accidents

_____year: _____
_____year: _____
_____year: _____

c) Do you bleed or bruise easily? Y N

3. Do you have any of the following? Please check the applicable boxes

( ) AIDS	( ) Arthritis	( ) Asthma	( ) Cancer
( ) Depression	( ) Diabetes	( ) Stroke	( ) Heart Disease
( ) Kidney Disease	( ) Pace Maker	( ) Epilepsy / Seizure	( ) Thyroid Dysfunction
( ) Hepatitis	( ) Metal Implants	( ) High Blood Pressure	

4. Are you presently taking any kind of **medication or nutritional supplement**?
Y N If yes, please specify.

Name	Dosage per day	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you on anti-coagulant medication? Y N

5. Allergies: Y N Type:_____

6. Chill/fever: Y N

7. Sweating: Do you sweat? Y N
If yes, ( ) day sweat ( ) night sweat ( ) spontaneous sweat at rest

8. Appetite / digestion
Appetite: ( ) normal ( ) increased ( ) decreased
Digestion: ( ) heart burn ( ) nausea/vomiting ( ) hiccups /belching/bloating
( ) sour regurgitation

9. Thirst: Y N If yes, do you desire: Hot ( ) Cold ( )

10. Stools / bowel ( ) Normal ( ) Constipation ( ) Diarrhea

11. Urine / Bladder Function
( ) Normal ( ) Increased frequency ( ) Urgency to go
( ) Difficulty urinating ( ) Pain or burning during urination

12. Pain: Are you experiencing any pain? Y N Where?_____
How would you rate your pain from a scale 0 to 10 (worst)? Score: _____

13. Sensation: ( ) numbness: where?_____ tingling?: where_____
( ) dizziness: how often?_____ when_____

14. Sleep ( ) normal ( ) increased ( ) decreased
Dreams: ( ) No ( ) seldom ( ) a lot ( ) nightmares

15. Energy level
Your energy in general: ( ) normal ( ) decreased
Concentration/memory: ( ) normal ( ) decreased
Are you physically active? Y N

16. Emotional state:
Which of the following emotions do you feel often?
( ) sadness ( ) grief ( ) anxiety ( ) worry ( ) irritability
( ) frustration ( ) anger ( ) insecurity ( ) fear

17. Ears & Eyes

Ears: tinnitus: Y N deafness: Y N

Vision: ( ) normal ( ) decreased others: _____

18. Do you experience or have you experienced any of the following in the past month?

( ) Shortness of breath ( ) Palpitations ( ) Pain or tightness in the chest

( ) Swelling (if yes, where_____)

( ) Skin problem (if yes, describe:_____)

19. Any information you would like your acupuncturist to know.

_____

_____

20. Females only

Pregnancy: Are you pregnant presently? Y N If Yes, how many weeks: _____

# of pregnancy: _____ # of births: _____ ( ) hemorrhage

Menses: Age at last menses (if you are post-menopausal): _____

Cycle: ( ) regular ( ) irregular ( ) early period ( ) late period Duration: _____

Amount: ( ) normal ( ) scanty ( ) excessive

Color: ( ) normal ( ) dark ( ) pale ( ) purple/black

Quality: ( ) normal ( ) clots ( ) watery

Pain: ( ) yes ( ) no If yes, pain occurs before ( )/during ( )/after period( ).

Do you experience pre-menses syndrome (PMS)? Y N

Vaginal discharge: Y, N ( ) white ( ) yellow ( ) greenish & smelly

( ) vaginal dryness ( ) vaginal soreness

THANK YOU!

I hereby declare that the above information is correct and that I have not withheld any medical information or not showing-up. I consent to acupuncture treatments.

_____ _____

Patient Signature **Date**

_____

Parent or Guardian Signature for patient age under18 years old

We are trying to provide a flexible schedule for you to receive acupuncture treatment at this clinic. However, to avoid delay of other patient's treatment, please let us know 48 working hours prior to your appointment if you cancel the appointment. Otherwise, $90.00 will be charged for a late cancellation. I hereby declare to follow this policy.

_____ _____

Patient's Signature **Date**

PATIENT CONSENT TO TREATMENT

1. Risks of Treatment

Acupuncture

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or disease. I am aware that certain adverse side effects could include, but are not limited to: local bruising, minor bleeding, fainting, pain, or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. During treatment, I must immediately inform Dr. Sarah Quan or associates if at any time I feel uncomfortable. That may need the support of another person following treatment to ensure my continued safety.

Chinese Herbs, Nutritional Supplement and Foods

I understand that Chinese Herbs (including raw herbs and patent herbs) and Nutritional Supplements and Foods may be recommended to me to treat bodily dysfunction. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior treatment. If I experience any problems, which associate with these substances, I should suspend taking them and call the acupuncture clinic as soon as possible.

Cupping

I understand that I may be given cupping as part of my treatment to treat bodily dysfunction. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: temporary suction marks and redness at the site of cupping.

2. Guarantee of Results

I understand there can be no guarantee of effectiveness or improvement following treatment for any given conditions.

3. Change to Treatment

Based on the principle of acupuncture your treatment is liable to be changed or modified in the treatment period. I understand that change to treatment will not require further consent. I may refuse treatment at any time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____