CENTER FOR HEALTHY LIVING

Suite 6105, 873 85 Street, Calgary AB T3H 4C8
Ph: 403-769-0093 **Fax:** 403-769-6159

Acupuncture/Oriental Massage Health Information Sheet

Last Name:		**First Name:**	
Address:			
City/Prov:		**Postal Code:**	
Email:		**Gender:**	**M/F/Other**
Home Ph:	**Work Ph:**	**Cell:**	
Occupation:		**DOB: (mm/dd/yy)**	
Family Medical Doctor:		**Name of Insurance Provider:**	

Referred By _____

Health History: ***Please check symptoms/problems you have had in the past year:***

1. **General:**

Chills( ); Depression( ); Dizziness/Faint( ); Headaches( ); Migraine( ); Fever( ); Forgetfulness( ); Tension( ); Nervousness( ); Numbness( ); Sweats( ); Sleep Deprivation( ); Weight Loss( ); Arthritis( ); Allergies( ); Other____

2. **Muscle/Joint/Bone having pain, weakness, or numbness in:**

Arms( ); Elbow( ); Neck( ); Shoulders( ); Upper Back( ); Lower Back( ); Hips( ); Knees( ); Legs( )

3. **Cardiovascular:**

Heart Disease( ); Stroke (TIA)( ); Anemia( ); High/Low Blood Pressure( ); Irregular Heart Beat( ); Rapid/Slow Heart Rate( ); Varicose Veins( ); Poor circulation( )

4. **Gastrointestinal:**

Poor Appetite( ); Bloating( ); Bowel Changes( ); Constipation( ); Diarrhea( ); Excessive Hunger( ); Excessive Thirst( ); Gas( ); Indigestion( ); Nausea/Vomiting( ); Stomach Pain( )

5. **Urinary:**

Frequent Urination( ); Lack of Bladder Control( ); Painful Urination( ); Renal Stone( )

6. **Eye, Ear, Nose, Throat**

Blurred vision( ); Crossed eye( ); Double vision( ); Sinus problems( ); Hay fever( ); Hoarseness( ); Persistent cough( ); Difficulty swallowing( ); Earaches( ); Hearing loss
( ); Ringing in Ears( ); Nosebleeds( )

7. **Skin**

Bruise easily( ); Hives( ); Itching( ); Changes in moles( ); Rash( ); Eczema( ); Psoriasis( )

8. **Reproductive**

Men only: Erectile difficulties( ); Prostate problems( ); other_____
Women only: Breast lump( ); Menstrual problems( ); Pregnant now( ); other_____

Please list any illness or surgeries and their dates:_____
Please list any accidents and their dates:_____
_____

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/Seizures( )	Thyroid Dysfunction( )
Hepatitis( )	Metal Implants( )	High Blood Pressure( )	

Current history

What brings you in for an Acupuncture & Chinese Medicine?

Have you consulted a medical doctor about the condition for which you seek Traditional Chinese Medicine treatment? Yes____, No____

Have you received any treatment in other clinic (include Acupuncture & Herbs)? Yes____, No____
If yes, describe what type treatment and medication you have been given (when, where, how long, name of medication, dosage; etc.)

Are you currently taking any kind of Medication or Nutritional Supplement?
If yes please specify:

Name	Dosage per day	Reason for taking

Do you bleed or bruise easily? Y___, N___
Are you on anti-coagulant medication? Y___, N___
Allergies: Y___, N___ Type_____

Pain: Are you experiencing any pain now? Y___, N___ Where_____
How would you rate your pain from a scale of 0 (least) to 10 (lots)? Score_____

Sensation: numbness ( ): where_____ tingling ( ): where_____
( )dizziness: how often_____ when_____

Energy level:
Your energy in general: normal ( ), decreased ( )
Concentration/memory: normal ( ), decreased ( )
Do you feel tired? Always ( ), Sometimes ( )

Hobbies:
Do you smoke? Y___, N___; How many cigarettes per day_____
Do you like to drink? How much_____(ml)
Other hobbies_____
Are you physically active? Yes____, No____

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

Do you experience or have you experienced any of the following in the past months?
Shortness of breath Y__ N__; Palpitations Y__ N__; Pain or tightness in chest Y__ N__;
Swelling Y__ N__, where_____ ; Skin problems Y__ N__, Describe_____

I understand that I am receiving a consultation from Dr. Raymond Liu, DTCM, (Doctor of Traditional Chinese Medicine) and that subsequent diagnosis and treatment (which may include acupuncture, acupressure, massage, cupping, moxibustion, Chinese herbs, etc.) are not based upon an Allopathic/Biomedical framework but, rather, according to the logic and criteria prescribed by Traditional Chinese Medicine. The first appointment will consist of an initial assessment including a medical history interview, and a treatment, which will take approximately 70-90 minutes. Follow-up treatments will be approximately 60 minutes.

Furthermore it is my desire to receive treatment according to Traditional Chinese Medical Theory and I take full responsibility for the choosing and administering of these therapies. I understand that I may experience some bruising, soreness or numbness after treatment, and that this is a normal reaction.

I understand that TCM (Traditional Chinese Medicine) is not covered by Health Care and therefore I am responsible to pay all costs incurred per visit. Payment is to be made upon rendering of services. I am aware that if seeking treatment under an insurance claim I am responsible for the payment of all costs incurred during treatment and will submit receipts or statements received for reimbursement to the insurance company myself.

_____	_____
Name of client (Please print)	Name of Acupuncturist/TCMD
_____	_____
Signature of client	Signature of Acupuncturist/TCMD
_____	_____
Date	Witness