QUANTUM HOLISTIC HEALTH ***– PATIENT INTAKE FORM***

Please take a few minutes to complete this form to the best of your ability. The information provided in this form will give us a general overview of your health condition from a Traditional Chinese Medicine perspective. It will also help us in preparing a treatment plan that will best meet your individual health needs and goals.

CONFIDENTIAL PATIENT INFORMATION

Name: ____ Mr. Mrs. Ms. Date: ___________________

Address:____ Profession: ___________________

Telephone: H: _______________________ C: _______________________ W: _____________________

Email: ____ DOB: _____________________ Age: _____

MSP #: _________________________ Any extended health care: ______________________________

Emergency Contact: ____________________________ Phone: _____________ Relation: ___________

MOST RECENT HEALTH CARE INFORMATION

Family Physician: ____ Phone: _____________________

Address: ____

Date of last physical exam: _______________________ Any abnormal findings? **Y** **N**

If yes, please explain: ____

Are you currently pregnant? **Y** **N**

Are you currently under the care of a health care practitioner? If yes, please explain.

____

Have you ever been treated by alternative health care practitioners? If yes, please provide the names of the providers and the dates of treatments.

____

Is this your first Traditional Chinese Medicine consultation / acupuncture? **Y** **N**

How did you hear about us? ____

<u>CURRENT HEALTH CONCERNS</u>

Chief complaints

Health concerns (List in order of importance)	**How long?**

What do you believe is the cause of your primary concern(s)?

____

Please check (√) the box for condition #1 above:

□ Is getting worse □ Is constant
□ Is worse in the morning □ Is worse in the afternoon □ Is worse in the evening
□ Interferes with school/work □ Interferes with movement a/o exercise □ Interferes with sleep
□ You have had this or similar conditions in the past
□ Notice it more during ____

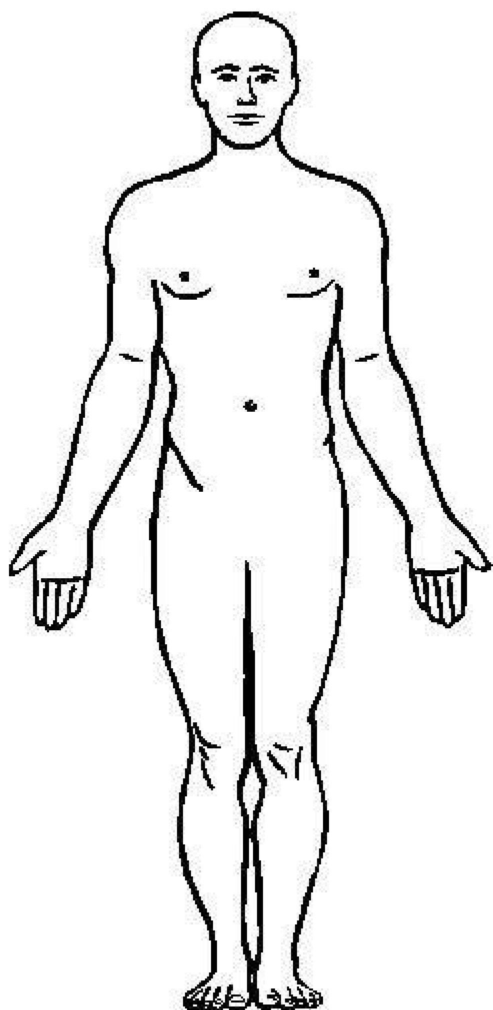
History of current health complaints
Please <u>briefly</u> describe the history of your current health concerns.

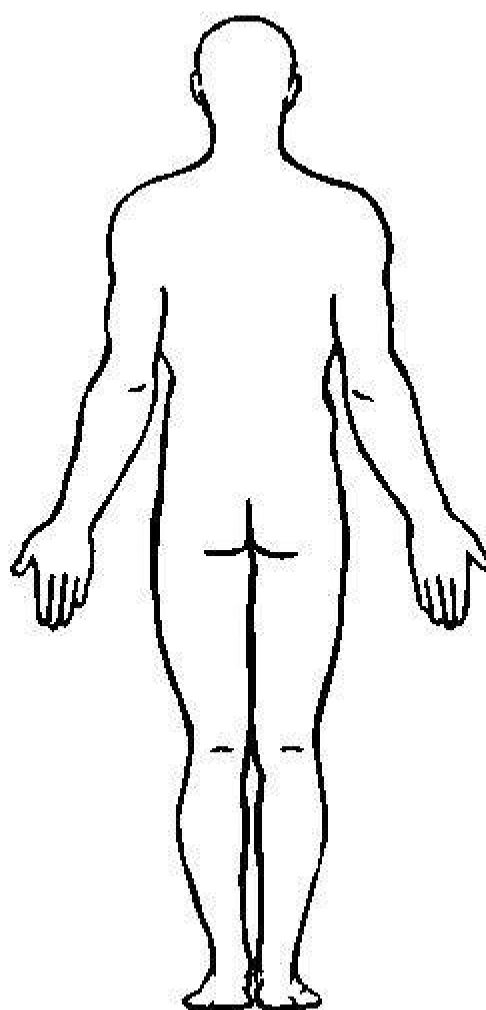
Do you have a diagnosis from your family physician/specialist. If yes, what is it ?

If you have any tests, X-ray, MRI, CT scan etc., please bring a copy of the report with you. If you don't have a copy of the report, please describe briefly the findings.

Please list the treatments you had so far. Any improvement from these treatments?

Please make a cross or circle in the areas of pain, discomfort and injuries.
Please rate them from 1 to 10. (10 being the most severe).





If you are struggling with chronic pain, please share your experience below. We would appreciate it.

MEDICAL HISTORY

MEDICATIONS *List all pharmaceutical medication(s) and dosage(s)that you are currently taking.*

1 ____ 2 ____

3 ____ 4 ____

5 ____ 6 ____

Are you **allergic** to any medications? **Y N**

If Yes, please list: ____

What is your reaction to these medications? ____

____

Please list any allergies to foods, drugs or other allergens in your environment.

____

Please check (√) any of the following that you take:

□ Antacids (Rolaids, Tums)
□ Antihistamines (Claritin, Benadryl)
□ Cortisone (cream or pills)
□ Cough & cold medications
□ Diet pills, appetite suppressants
□ Laxatives
□ Oral contraceptives or HRT
□ Sleeping pills
□ Pain relievers (aspirin, Tylenol, Aleve, Motrin)
□ Thyroid medication

What major injuries, hospitalizations or surgery have you had? Please give dates and reasons.

____

____

Have you ever had a blood transfusion? **Y N** If yes, when? ________________________________

Please check those that are applicable.

□ Bone Density Scan (DXA)
□ Colonoscopy/Sigmoidoscopy
□ CT Scan
□ Endoscopy
□ Electrocardiogram (ECG/EKG)
□ Electroencephalogram (EEG)
□ Echocardiogram (Echo)
□ Laparoscopy
□ Mammogram
□ MRI
□ Ultrasound
□ X- ray
□ Other ____

Have you had the following childhood illnesses? (√) if you have, leave blank if unsure:

□ Diphtheria □ German Measles □ Measles □ Mumps □ Rheumatic Fever □ Scarlet Fever
□ Strep Throat □ Other ____

Do you suffer or had suffered from any of the following conditions.?
Please circle any applicable conditions.

Diabetes	Heart Disease	High Blood Pressure	Arteriosclerosis	Bleeding	Edema	Obesity
Eczema	Asthma	Multiple sclerosis	Kidney Disease	Gallstones	Hepatitis	Cirrhosis
Migraine	Alcoholism	Eating Disorder	Drug Addiction	Arthritis	Osteoporosis	HIV
Epilepsy	Tuberculosis	Mental Illness	Depression	Anxiety	Peptic Ulcer	Herpes

Other: ____

Do you smoke cigarettes, consume alcohol or use drugs? If yes, how much? (Confidential)

____

Please list any hereditary diseases or major illnesses of family members in the space provided.

____

____

Please use the space below for any additional information that you think might be helpful:

Informed Consent for Traditional Chinese Medicine (TCM) Diagnosis and Treatment

This consent covers the following TCM treatment modalities:
• Acupuncture (various forms) • Cupping and Moxibustion • Gua Sha • Tui Na (Chinese medical massage, including acupressure) • Herbal Therapy and supplements • Medicated Diet and Nutritional Therapy• Meditation and Breathing Techniques • Qi Gong• Non-needle acupuncture with micro-current and light therapy • Low level laser Therapy • Blood Letting Therapy

I acknowledge that I have discussed, or have had the opportunity to discuss, the nature and purpose of TCM treatment(s) in general and my treatment(s) in particular, as well as the contents of this consent, with my Registered Acupuncturist and TCM Practitioner.

With regard to acupuncture, I have been advised that all needles are pre-sterilized and are disposed after each use. I further understand and am informed that, as with all health care, the practices of acupuncture, cupping, moxibustion, bleeding, tui na and microcurrent and light therapy pose **slight risks**, which may include, but are not limited to: temporary bruising, soreness or sensitivity in the area(s) treated, swelling, blistering, bleeding, light-headedness or fainting, nausea, infection and shock.

I also understand that adverse reactions or interactions between recommended herbs, herbal formulas or foods with prescribed medications, supplements or natural health products, though rare, may occasionally occur.

I hereby consent to traditional Chinese medical diagnosis and treatment as described to me by my Registered Acupuncturist and TCM Practitioner. I intend this consent to apply to all my present and future TCM care.

______________________________	____	________________________
Patient Signature	Patient Name (Printed)	Date
______________________________	____	________________________
Witness Signature	Witness Name (Printed)	Date

I have read the following and understand that:
• I am responsible for my own health.
• It is my responsibility to inform the Registered Acupuncturist/TCM Practitioner of any medical conditions or allergies that I am aware of and any medications/supplements/herbs that I am currently taking.
• It is my responsibility to inform the Registered Acupuncturist/TCM Practitioner if I am pregnant, may be pregnant or am breast feeding.
• While changes in habits are not a pre-requisite for treatment, failure to follow the recommended dietary and/or lifestyle programs could undermine expected results. I understand that it takes time to feel better when using TCM. I accept that positive changes will occur more rapidly with increased compliance.
• It is my responsibility to clarify treatment issues with my Registered Acupuncturist/TCM Practitioner.
• I am free to discontinue treatment at any time.
• I accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered.

Canceling or rescheduling appointments must be done 24 hours in advance and that I will be charged for missed appointments.

______________________________	____	________________________
Patient Signature	Patient Name (Printed)	Date