Appointment Date:

General Information

Name _____ Date _____

Address _____ City _____ Province _____ Postal Code _____

Married Single Partner Divorced Widowed Date of Birth _____ Care Card # _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____

Have you had Acupuncture or Oriental medicine before? Yes No

Are your presently under a doctor's care? Yes No Who and for what? _____

Are there any other therapies which you are involved in? Who and for what? _____

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other _____

What are your health goals? _____

List any past or future surgeries. _____

_____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) _____

_____

List exercise and sport activities you have been or are currently involved in: _____

_____

Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth/gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss/gain
- ❍ Wheezing

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? _____

❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

Medical History

Do you have any allergies? Yes No If so, to what? _____

Do you take medication? Yes No If so what types and how often _____

Do you take supplements? Yes No If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When?_____ Do you have a low point during the day? Yes No When?_____

What are your indulgences?_____

What are your hobbies/pleasures? _____

Web of Wellness

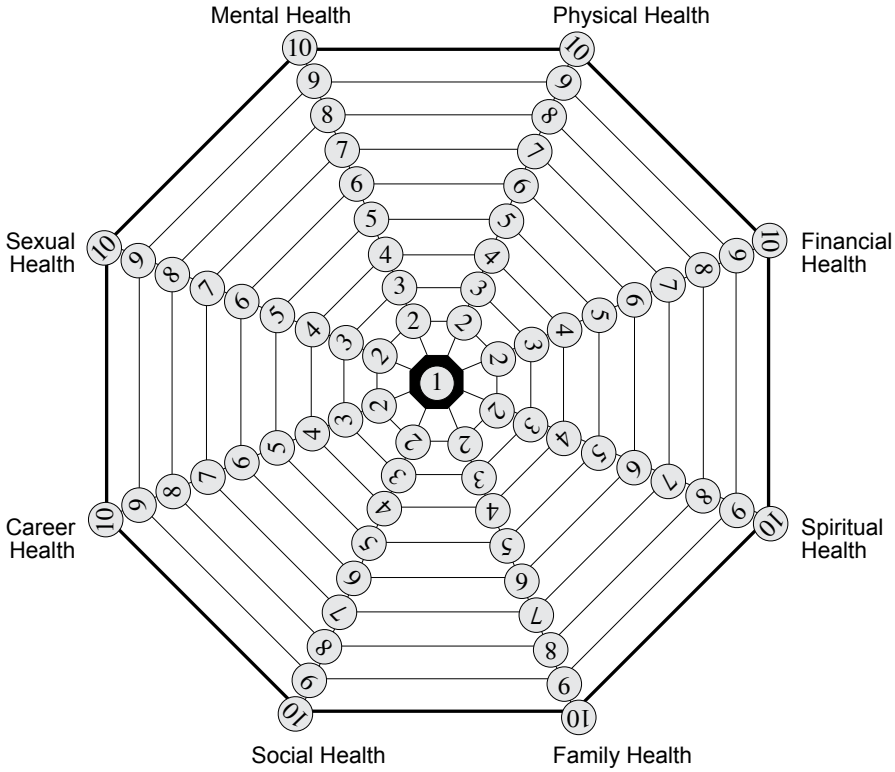
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

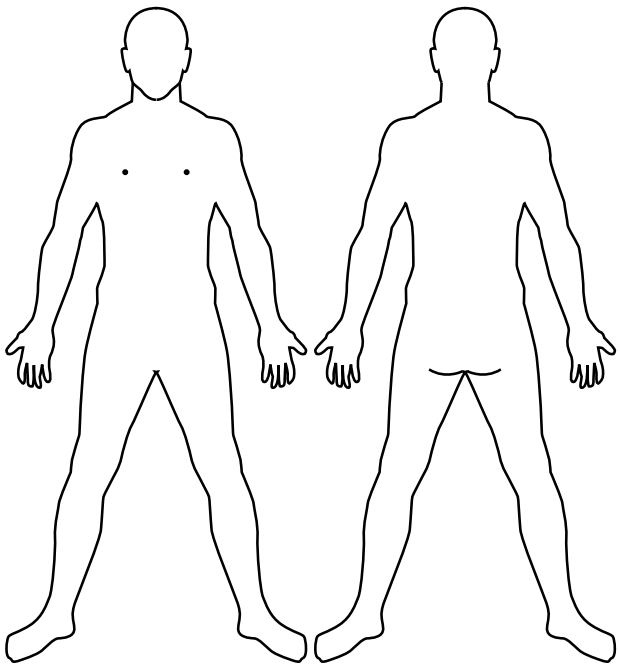
All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit



Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.

Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

(Signature) _____ (date) _____

Open Gate Acupuncture & Herbal Clinic

Dr. Danielle McFadzen, DTCM
Alice Young-Clark, TCMP, R.Ac

INFORMED CONSENT

Once reading the following information, please ask your practitioner if you have any questions.

While the traditional Chinese medicine practices of acupuncture, electro-acupuncture, cupping, moxibustion, gua-sha, tui-na and shoni-shin are considered to be safe treatments, you should be aware that the following side effects may occur:

Residual needle sensation - occasionally there is a residual sensation at the point of insertion that may last for a period of time. Please advise your practitioner if this sensation lasts for several days.

Drowsiness or dizziness - these symptoms are more common if you are hungry or dehydrated at time of treatment. Fainting, while very rare, is also more likely in this case. Please eat and drink prior to your appointment.

Bruising or bleeding - this may occur at the site of insertion.

Temporary aggravation of symptoms - this will occasionally occur prior to improvement. Rarely will worsening of symptoms last beyond the first day or two.

The herbs used in traditional Chinese medicine (which can be from plant, animal, or mineral source) that have been recommended for use are considered safe. Some of the herbs may be inappropriate during pregnancy, or while taking other medication. It is important to inform your practitioner of all these situations and conditions. Please inform your practitioner if you feel you are having adverse reactions to your herbal therapy.

STATEMENT OF CONSENT TO TREATMENT

As a patient of Open Gate Acupuncture & Herbal Clinic, I have read the information and understand that this form of medical care is based on Traditional Chinese Medicine (TCM) principles and practices. I recognized that all the practitioners that are working with me may have access to my file and will ensure all the information is private and confidential. I also recognize that even the most gentle of therapies potentially have complications, and hence the information provided must be complete and inclusive of all health concerns including pregnancy, significant medical history and all medication (including over the counter drugs and supplements).

I do not expect my practitioners to be able to anticipate all the risks and complications associated with treatment. I have been informed that certain reactions to treatment may occur (listed above). I also understand that there are possible side effects to herbal therapy and will cease use and inform my practitioner immediately if this occurs. I will also inform my practitioner immediately if I am pregnant.

I hereby request and consent to acupuncture, herbal therapy or any other practices within the scope of TCM. I also confirm that I have the ability to accept or reject this care and treatment of my own free will and choice. **I accept full responsibility for fees incurred during this care, and agree to the 24 hour cancellation policy of this clinic. I will be charged for any missed appointments if 24 hour notice is not given.**

Name (please print): _____

Signature: _____ Date: _____