MO .ACUPUNCTURE & MASSAGE CENTER

ACUPUNCTURE CASE FORM NO._____

_____

Name _____ Occupation _____

Age_____Gender _____ Date _____

Address _____

City_____Province_____ Post code_____

Referred By _____

Phone:_____(Cell) _____(Home)

_____(Work)

Marital Status

Married ___ Single ___ Divorced ___ Widow/widower___

Weight _____kg or _____lbs Height_____

Any bleeding disorder_____ Hepatitis B_____HIV _____

Any injuries/ accident_____

Please continue to answer questions on the next 3 pages.....

Doctor's Use

Summary

_____

_____

_____

_____

Inquiry Sheet

This inquiry sheet is used only to help the doctor diagnose, differentiate, and to design a treatment. All of the information is completely voluntary, and will not be shared with anyone else, without your full knowledge and consent.

1. What is your main reason for this visit? And how long have you had the disorder?

_____

2. Did your Family Doctor diagnose your complaint? If so, what were the findings?

_____

3. Have you ever seen an acupuncturist or Chinese herbalist for your complaint?
Yes ☐ No ☐

4. Does anyone in your family suffer the same complaint?
Yes ☐ No ☐

5. Have you ever taken medication for more than 5 months, for any illness?
Yes ☐ No ☐

If Yes,

A) _____ (Drug Name) for _____ (Disease or illness)

B) _____ (Drug Name) for _____ (Disease or illness)

6. Do you have a history of allergies?
Yes ☐ No ☐

If yes, what are they? _____

7. Do you drink:
Coffee ☐ Wine ☐ Beer ☐

If so, how much?
Coffee 1/ 2/ 3/ 4/ 5+/ cup(s) per Day/ Week
Wine 1/ 2/ 3/ 4/ 5+ cup(s) per Day/Week
Beer 1/ 2/ 3/ 4/ 5+ cup(s) per Day/Week

8. Do you suffer from? hypertension ☐ diabetes ☐
heart disease ☐ arthritis ☐

If yes, for hypertension, what is your blood pressure? _____

9. How much sleep do you get?
a) 1-3 hours ☐ 4-6 hours ☐ 7-9 hours ☐ over 10 hours/day ☐
b) sleep with nightmare(s) ☐ sleep with lots of dreams ☐
c) feel tired after you wake ☐
d) are you taking sleeping pills? Yes ☐ No ☐

10. Your eating habits and digestion:
a) Your appetite is: Good ☐ Bad ☐
b) Do you feel full after eating? Yes ☐ No ☐

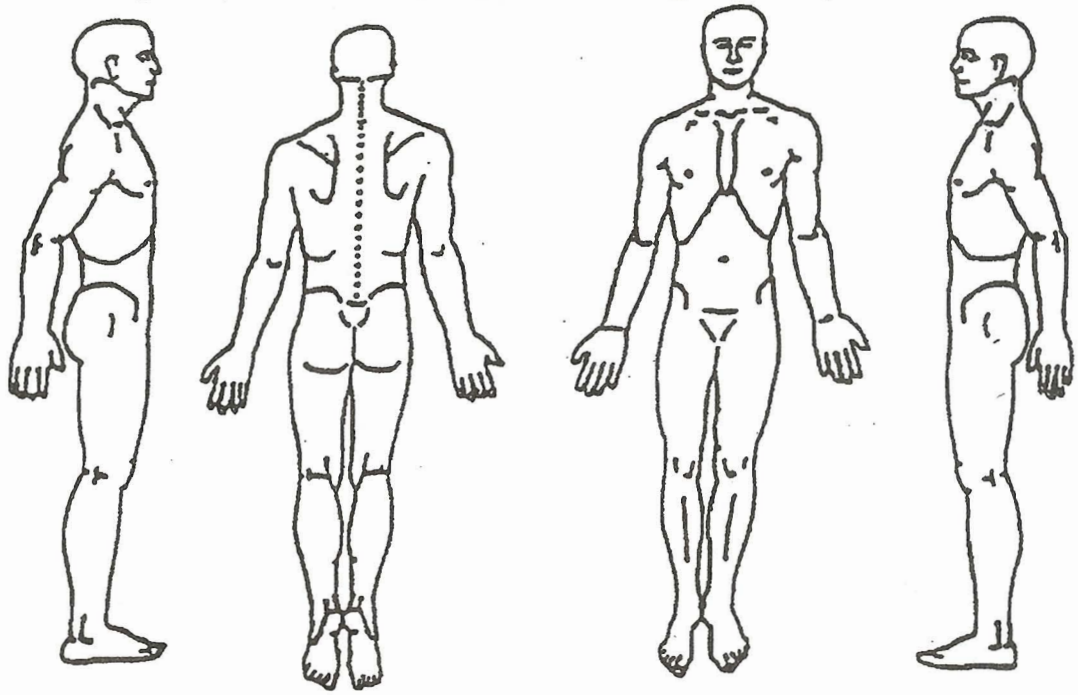
c) Do you prefer your food and/or drink: warm ☐ cold ☐ both ☐
d) Do you have a: bitter/ sweet/ sour/ salty/tasteless taste in your mouth?

11. Bowel movements:
Stools are: loose ☐ medium ☐ hard ☐
If loose, how many times/day
1-2 times/day ☐ 3-4 times/day ☐ Over 4 times/day ☐
If hard, once in how many days.
One day ☐ 2days ☐ more than two days ☐

12. Urination:
a) urine is clear ☐ turbid ☐ light yellow ☐ deep yellow ☐
b) urination is currently more frequent? Yes ☐ No ☐
c) urination is endless? Yes ☐ No ☐
d) how many times at night? 1/ 2/ 3/ 4

13. How about your perspiration?
a) Do you feel a cold sweat when physically active? Yes ☐ No ☐
b) Do you sweat spontaneously? ☐ Yes ☐ No
c) Do you sweat at night? ☐ Yes ☐ No

14. Do you usually feel thirsty ☐ Yes ☐ No If yes, how many cups of water ☐
15. Do you usually feel chilly? ☐ Yes ☐ No
16. Do you feel feverish without a high temperature? Yes ☐ No ☐
If yes, when do you experience this? During the day ☐ At night ☐ Other ☐
17. Do you feel pain in any part of your body? Yes ☐ No ☐
If yes, which part? *(Also mark where your pain is on the diagram BELOW)*



18. Do you Exercise?
Yes ☐ If not, why? _____
Feel tired easily upon exercising? Yes ☐ No ☐

19. Did/ do you feel cold in your hands/ feet? Yes ☐ No ☐

20. Did/ do you feel numb? In your hands/ feet/ arms/ legs?
Did/ do you feel stiff? In your hands/ feet / arms/ legs?

21. Are you easily frightened? Yes ☐ No ☐

22. Do you have a quick temper or fall into a bad temper? Yes ☐ No ☐

23. Your sexual activity:
a) used to be sexually active? Yes ☐ No ☐
b) sexually active recently? Yes ☐ No ☐
If not, do you suffer from impotence? Yes ☐ No ☐

24. Do you have any other complaints/ symptoms?

_____

_____

25. For females, only:
a) when was your last period? _____

b) is your period normal? Yes ☐ If no, what is the irregularity? _____

_____

26. Have you consulted with your family doctor/ specialist, about acupuncture?
Yes ☐ No ☐

27. Does your insurance cover acupuncture? Yes ☐ No ☐

Thank you for giving us this important information!

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INFORMED CONSENT FOR ACUPUNCTURE

DR. LINGLING QIN, RAC

I have had the opportunity to discuss with the Registered Acupuncturist and/or with other clinic personnel about the nature, procedure and purpose of Acupuncture and procedure. I understand and I am informed that, as in all health care, in practice of Acupuncture, even though all needles are pre-sterilized and disposable, there are some slight risks to treatment, but not limited, such as local temporary soreness, redness, swelling, and infection and other risks, including bruising, bleeding, nausea, fainting, blister, or shock. For my safety, I will inform Dr. immediately if I feel faint, confused, nauseous or other abnormal condition(s) during or after treatment, so that the concern is addressed and attention and caution will be exercised. I do not expect the Acupuncturist to be able to anticipate and explain all the risks and complications and wish to rely on the Acupuncturist to exercise judgment during the course of the procedures which the Acupuncturist feels at the time, based upon facts then known, are in my best interest.

As certain Acupuncture points and treatment are contraindicated for menstruating or pregnant women, I will inform the practitioner of any such condition prior to any given treatment. If there is any part of my body that I do not want to be touched or subjected to treatment, there are list below:

_____

I (client's name)_____, have read the above information. I have also had an opportunity to ask questions about its content, and I agree to inform and up-dated all my health conditions to Dr. during the whole course of treatment. Failing to do so, I will release the Acupuncturist from any Liabilities. I hereby request and consent to the performance of Acupuncture and other procedures related to Acupuncture, including needling, electro Acupuncture, if necessary, moxibustion, cupping, guasha, laser, Acupressure and other techniques within the scope of practice of Acupuncturist during the whole course of my treatment. I understand that if missed appointment without 24 hour notice, I may be incurred $40 fee charge. I understand that the package provided is valid in 6 months from the time I purchased, and is non-refundable.

Patient's Printed Name:_____ Date:_____

Patient's Signature:_____