R.TCM & R. AC

350 Hwy 7 East, #211
Richmond Hill, OntarioL4B 3N2

NEW PATIENT QUESTIONNAIRE

Please note: The ability to draw accurate conclusions about your present state of health and to discern the effective ways to optimize your health depends other information that you provide.

Today's Date:_____

Name:_____

Address:_____

City:_____Province:_____PostalCode:_____

Phone

Numbers: Home: ( )_____

Cell: ( )_____

Work: ( )_____Ext: _____

Email: _____

Please circle which number or way is the best to reach you for appointment reminders.

Date of Birth: Month: _____Day: _____Year: _____Age:_____

Emergency Contact Info:_____

Profession:_____Phone:_____

How did you hear about our office: _Word of mouth _Web site _Mail ___Walk In _other_____

Please state your primary reason for attending this office and any additional concerns.

If possible, please indicate when you first noticed the condition of concern.

Past Medical History (includedate)

Surgeries (major and minor):

Significant Illnesses: ____Cancer _____Diabetes _____Hepatitis _____Heart Disease _____Seizures

____High Blood Pressure ____Thyroid Disease_____Covid-19

____Other (please specify) _____

Significant Trauma/Stress: ____Auto Accident _____Own Birth _____Falls

____Divorce/Loss _____Giving Birth _____Job Loss

____Other (please specify)_____

Allergies (drugs,chemicals,food):

Medicines or Herbs currently taking:

Medicines or Supplements taken for a prolonged period in the past:

Treatments, therapies or alternative/complementary services:

Average Daily Diet:

Morning Afternoon Evening

Habits:____Coffee____Cigarettes____Tea____Cola____Alcohol____Drugs____Salt____Sugar/Sweets__
__Other_____

Family History : ____Diabetes ____Cancer ____High Blood Pressure ____Stroke

____Asthma ____Allergies ____Alcoholism

____Other_____

General: _____Poor Appetite ____Heavy Appetite ____Poor Sleep ____Heavy Sleep

_____Tremors____ Fatigue_____ Insomnia ____Vertigo

_____Cold Hands ____Cold Feet ____Cold Back ____Fevers

_____Chills ____Night Sweats _____Cravings ____Localized Weakness

_____Poor Coordination ____Appetite Changes ____Sudden Drop of Energy at ____(time)

_____Strong Thirst (Hot/Cold Drinks)

Skin and Hair :____Rashes ____Ulcerations ____Hives ____Itching

____Eczema ____Pimples ____Purpura ____Dandruff ____Loss of Hair

____changes in hair and skin ____Other_____

Head, Eyes, Ears, Nose, Throat: ____Dizziness ____Concussions ____Migraines

____Glasses _____Eye Strain ____Eye Pain ____Poor Vision

____Night Blindness ____Colour Blindness ____Cataracts ____Earaches

____Blurry Vision ____Ringinginears ____Poor Hearing ____Nose Bleeds

____Sinus Problems ____Mucus ____Dry Throat ____Dry Mouth

____Copious Saliva ____Eye Spots _____Facial Pain ____Grinding Teeth

____Sores on lips/tongue ____Jaw Click ____Headaches____

Other head or neck problem_____

Cardiovascular: ____High Blood Pressure ____Low Blood Pressure ____Chest Pain

____Dizziness ____Irregular Heartbeat ____Fainting ____Cold Hands and Feet

_____ Phlebitis ____Swelling of hands/feet ____Blood Clots ____Difficulty Breathing

____Other_____

Respiratory: ____Cough ____Coughing Blood ____Asthma

____Bronchitis ____Pneumonia ____Tight Chest

____Difficulty in breathing when lying down

____Production of phlegm ____Colour_____

Gastrointestinal:____ Nausea ____Vomiting ____Diarrheal ____Gas

____Belching ____Black Stools ____Bad Breath ____Rectal Pain

____Constipation ____Bloody Stools ____Hemorrhoids ____Sensitive Abdomen

____Pain or Cramps ____Laxative Use: ____times per week/type_____

____Bowel Movement: ____Frequency ____Colour ____Odour ____Texture and form

Genito-Urinary:____ Pain on Urination ____Frequent Urination ____Blood In Urine

____Urgency to Urinate _____Unable to Hold Urine _____KidneyS tones

____Venereal Disease ____Impotency

____Wake up to Urinate, how often_____/night; time_____

Pregnancy and Gynaecology: ____Number of pregnancies ____Number of births ____Premature births

____Miscarriages ____Age at first menses ____Period(days)____Duration

____Irregular Period ____Flow(describe)____Clots ____Last PAP_____

____Last menses ____Vaginal Discharge ____Vaginal Sores___Menopause

____Birth Control Type and Duration:_____

____Changes in body/psyche prior to menstruation

Musculoskeletal:____NeckPain____MusclePain/Cramps____BackPain____JointPain
____Other_____

Neuropsychological :_____Seizures ____Areas of Numbness ____Poor Memory ____Concussion

____Depression ____Anxiety ____Bad Temper ____Easily Stressed

____Considered/Attempted Suicide ____Treated for emotional problems

____Other neurological/psychological problems_____

TCM Acknowledgement and Informed Consent

I, _____

Patient's Name. Please Print.

Hereby acknowledge and confirm that prior to signing this document and prior to undergoing

any treatment by a R.Ac or R.TCMP

1. I have been informed and understand that nature; risk and reason of any treatment or advice provided from TCMP or Ac to me only proceed if my consent is given.

2. I have understand the TCM techniques such as Acupuncture, acupressure, electrical stimulation, cupping or moxibustion , gua sha and Chinese tuina massage has the risk and symptoms like: slight pain, light headedness or nausea, soreness, bruising, bleeding or discolouration of the skin and possibility of other unforeseen risk, I freely accept the risks involved with my procedure. Any potential side effects that may be associated with TCM Treatment Plans and Herbs have been clearly indicated.

3. I will inform my practitioner if current have or develop any major health issue, bleeding disorder ,use a pacemaker carrying or to have any infectious agents such as HIV TB and Hepatitis, my practitioner may withhold treatment.

4. I understand that there are no guarantees for the results of my treatment. TCM do not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

5. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through the third party insurance. I am responsible for the full and prompt payment after services has been rendered I, further acknowledge and agree that I will be charge the full fee for all and any missed appointment unless I have advised the office of my cancellations no less than 24 hours in advance of the scheduled appointment.

I hereby authorize and consent to such treatment(s) as the TCM Practitioner considers necessary.

Patient's or Guardian's Signature _____ **Date** _____

Practitioner's Signature _____ **Date** _____