Hañnah Wang, RAc

Acupuncture & Traditional Chinese Medicine

Consent and Information Form

Welcome to Colwood Back to Back. I would like to take this opportunity to share some important information related to your treatment.

Traditional Chinese Medicine and Acupuncture are very effective healing modalities which have been observed, practiced, and perfected over 3500 years. In this system of medicine, the body has been mapped out into a series of pathways, or meridians. Stimulation of specific locations along these meridians has proven to be very effective in treating a wide range of health imbalances. Recently, modern electromagnetic research has confirmed these specific locations. Acupuncture involves the insertion of fine sterile, disposable needles into these points. The needles themselves are of the highest quality, and are often no thicker than a human hair. As such, their insertion often creates little to no discomfort. In fact, once the treatment begins, most people will experience a calm feeling of relaxation.

Although infrequent mild bruising at the insertion site can occur, there is an extremely low rate of adverse affects to acupuncture. British Columbia has extensive training and safety requirements for Acupuncturists and Traditional Chinese Medicine Practitioners. As a result, complications such as pneumothorax or nerve injury are extremely rare. We are, however, required by law to advise you of these risks.

The use of Traditional Chinese Medicine Herbs may be recommended and prescribed according to the patient's needs. Only the finest quality herbs are used in this clinic.

All information related to your file will be kept confidential. The accompanying Comprehensive Health History is designed to determine how to best treat your health concerns. Please answer to the best of your ability. It is my goal to provide a safe, comfortable, and effective environment for your treatments. If at any point you have questions or concerns, please do not hesitate to communicate them with me.

If you are comfortable with the information presented, and you consent to treatment, please sign below.

_____ _____

Signature Printed Name

_____

Date

Confidential Health History

Name: _____
Address: _____
_____
Occupation: _____
Phone: Home: _____ Work: _____
Cell: _____ E-mail: _____
Please check the method of reminder you would prefer:
Text ◯, E-mail ◯ OR Phone Call ◯

Cell phone provider: _____
Date of Birth: _____ Sex: _____
Doctor's Name: _____
Emergency Contact:
Name: _____ Ph #: _____
Referred By: _____

Present Condition:

Chief Complaint:

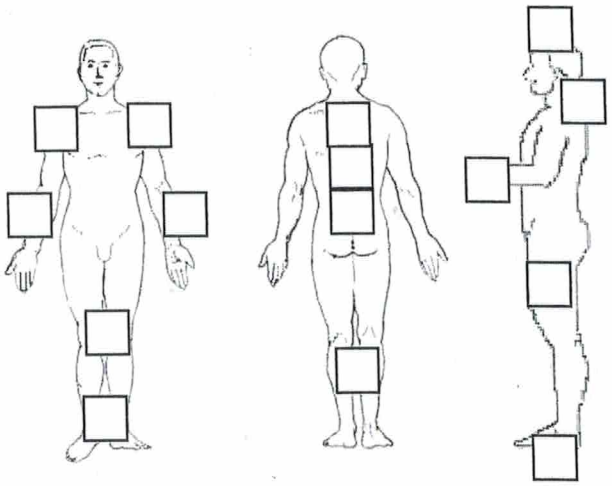
History and Characteristics of Chief Complaint:

If you are currently experiencing any pain, numbness, or physical discomfort, please indicate location on the diagrams to the right.

Please note below any treatments you have sought for this condition:

What makes this condition feel better?

Worse?



Health History: Please check conditions you currently have (√) or have had in the past (✕):

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune Disorder
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Chronic Cough
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fatigue Problem
- ☐ Fibromyalgia
- ☐ Gallbladder Problem
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Impotence
- ☐ Insomnia
- ☐ Intestinal Disorder
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Menstrual Disorder
- ☐ Migraine / Headaches
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Stomach Disorder
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Vaginal Infection
- ☐ Whiplash

Symptoms: Using a scale of 1, 2, or 3, please note below any symptoms you have had in the past year. A "1" would indicate a mild occurrence, a "2" would indicate increased severity, and a "3" would be the most severe.

General:
- Fatigue
- Insomnia
- Disturbed sleep
- Frequent dreams
- Excessive sleep
- Dislike of cold
- Dislike of heat
- Weight loss
- Weight gain
- High fever
- Chills
- Hot flashes
- Night sweats
- Unusual daytime sweats
- Lack of sweat when hot
- Extreme thirst
- Thirst with no desire to drink
- Edema or swelling

Skin:
- Rashes
- Hives
- Dry skin
- Oily skin
- Acne
- Easily bruised
- Skin feels tight or cracked
- Dry or brittle nails
- White spots on nails

Head & Neck:
- Headaches
- Muzzy or heavy feeling in head
- Dizziness
- Jaw pain

Eyes & Ears:
- Decreased vision
- Blurred vision
- Visual spots
- Night blindness
- Eye pain / swelling
- Red itchy eyes
- Ringing in the ears
- Decreased hearing
- Ear pain
- Ear discharge

Nose, Throat, & Mouth:
- Nose bleeds
- Excessive nasal discharge
- Frequent sneezing
- Change in sense of smell
- Sore throat
- Hoarse voice
- Difficulty swallowing
- Tight feeling in throat
- Toothache
- Bleeding gums
- Mouth or tongue ulcers
- Dryness or cracks around nostrils, lips or mouth

Muscles & Joints:
- Stiff neck
- Shoulder / arm / hand pain
- Hip / leg / pain
- Low back pain
- Knee problems
- Fullness or dullness below ribs
- Muscle cramps or twitches
- Stiffness when bending or standing up
- Aching in bones after prolonged standing or overwork
- Heavy limbs
- Swollen joints

Nervous system:
- Fainting
- Paralysis
- Tremors
- Poor balance
- Seizures
- Numbness or tingling

Heart, Lungs & Chest:
- Palpitations
- Chest pain or tightness
- Rapid heart rate
- Irregular heart beat
- Swelling of ankles
- Varicose veins
- Cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Asthma / wheezing
- Frequent colds
- Nasal polyps
- Sinus congestion

Mental / Emotional:
- Difficulty concentrating
- Poor memory
- Excessive worry
- Anxious
- Depression
- Easily Irritated
- Frustration or anger
- Fearfulness
- Stress
- Easy or uncontrolled excitability
- Nervous giggling or talkativeness

Digestive:
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Loose Stools
- Bloody / black stools
- Stomach pain
- Abdominal pain
- Poor appetite
- Excessive hunger
- Tired after eating
- Abdominal bloating/ gas
- Belching
- Indigestion
- Acid Reflux
- Hemorrhoids

Urinary / General:
- Painful urination
- Difficult urination
- Frequent daytime urination
- Frequent nighttime urination
- Incontinence
- Cloudy urine
- Bloody urine
- Genital pain, dryness or itch
- Genital discharge or lesions
- Low libido
- Excessive libido

Male:
- Impotence
- Weak urinary stream
- Prostate hypertrophy
- Premature ejaculation
- Seminal emissions

Female:
- Irregular periods
- Painful periods
- Bleeding between periods
- Passing of clots
- Scanty periods
- Early periods
- No periods
- Pre-menstrual grouchiness or moodiness
- Menopausal symptoms
- Breast pain or discharge
- Vaginal discharge

Please list any major **Surgeries** or **Traumas**:

Please list any **Medications** or **Supplements** you are currently taking, including dosages:

Please list any **Allergies** and the type of reaction involved:

Please indicate which substances you consume and indicate the amount:

Coffee: ☐

Tobacco: ☐

Alcohol: ☐

Recreational drugs: ☐

Do you **Exercise** regularly? If so please describe activity and amount.

Women Only: Please answer the following questions if applicable to you.

Please note the number of pregnancies you have had, the number of deliveries you have had, plus any relevant information:

Date of last menstrual period:

Date of onset of menopause:

Are you Pregnant?

Are you trying to become Pregnant?

Thank you for taking the time to fill out this Confidential Health History.