Application for Treatment

Personal Information

Date

Name				Insurance	☐Y ☐N
	First	Middle	Last	Gender	☐Male ☐Female
Address				Postal Code	
Date of Birth	yy mm dd		Occupation		
Phone	Home		Cell	Work	
Email			Emergency Contact		
Chief Complaint	The reason why you seek for Traditional Chinese Medicine.				
Current Medication	Please write here all medications that you are currently taking. Or let us have a photocopy of the list of medications you are currently taking.				
Physician			Contact Number		

Purpose of Visit

☐Consultation only ☐Consultation with Treatment	
Treatment Modalities	☐ Acupuncture ☐ Herbal Medicine ☐ Tuina Massage ☐ Other
Other	Please describe here other modalities such as moxibustion, cupping, Guasha, etc.

Past Traditional Chinese Medicine History

Have you ever been treated with Traditional Chinese Medicine? ☐ Yes ☐ No

If yes, please check any treatments you have received.

☐ Acupuncture ☐ Herbal Medicine ☐ Tuina Massage ☐ Moxibustion ☐ Cupping ☐ Other

Medical History

Your Past Medical History:		**Family Medical History:**
☐AIDS	☐Seizures	☐Cancer (Mother/Father/Other)
☐HIV	☐Thyroid Disease	☐Diabetes (Mother/Father/Other)
☐HVB (Hepatitis B)	☐Surgeries	☐High Blood Pressure (Mother/Father/Other)
☐Cancer	☐Venereal Disease	☐Heart Disease, Stroke (Mother/Father/Other)
☐Diabetes	☐Significant Trauma	☐Allergies (Mother/Father/Other)
☐High Blood Pressure	(auto accident, falls etc.)	☐Arthritis (Mother/Father/Other)
☐Heart Disease, Stroke	☐Childhood Illness	☐Seizures (Mother/Father/Other)
☐Allergies	☐None	☐None
☐Alcoholic	☐Other:	☐Other:
☐Arthritis		

Additional description of the above illness or allergies (Please write below)

Informed Consent for Traditional Chinese Medicine Treatment and Electronic Transmission

I hereby request and consent to receive Traditional Chinese Medicine (mentioned as TCM hereinafter) treatments including acupuncture, herbal medicine, Tuina massage, and other related modalities within the scope of practice of TCM practitioners and Acupuncturists performed in Mai Medical Health Centre.

I understand that, as with all health care, while rare, there may be some risks to treatment, including;

- With acupuncture:
  - Occasional bruising, post-needling sensation, fainting, miner bleeding, blistering, nausea, infection and shock.
  - Possible reasons for these symptoms are nervousness, hunger, extreme tiredness, muscle tension, or moving of the body after needling
- With herbal medicine:
  - Risk of reactions to treatment including nausea, vomiting, dizziness, headaches, malaise or general worsening of symptoms
  - Unknown interactions between western medications and Chinese herbal medicines
- Other modalities (Cupping Therapy):
  - Risks relevant to treatment such as bruising or bleeding and pain

I also understand that transitions in healing (known as healing crisis) may also produce temporary periods of discomforts including emotional upset, fatigue, malaise, headaches, dizziness, rashes or breakouts, nausea, vomiting or general worsening of symptoms. TCM treatments in general are safe and effective for the prevention and treatment of a wide range of health conditions and for the promotion of general well-being. However, it is not intended to replace tests or treatments recommended by your physicians.

I acknowledge that the above treatments and all their ramifications have been fully explained to me and I do not expect the practitioners to be able to anticipate and explain all possible risks and complications. I also absolve the clinic and its practitioners if I experience from any unexpected results of the treatment. I further agree to not commence lawsuit of any kind against all parties mentioned.

I hereby assigned benefits payable to the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. I authorize my health care provider to collect, use and disclosure personal information concerning any claims submitted on my behalf. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Name of the Patient/Guardian	Signature	Date: YY/MM/DD

Cancellation Policy

The clinic requires 24 hours notice when cancelling an appointment. Please be aware that a fee of $50 will be applied for late cancellation or missed appointment.

Cancellation Agreement

I understand that I am responsible for payment in full for appointments that are missed without 24 hours notice (1 business day).

I have read and agree to the above policy.

Name of the Patient/Guardian	Signature	Date: YY/MM/DD

General Health Information

To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly. Your answers will be kept totally confidential.

General information on your health condition		
Chills/Fever	☐general chills (☐mild ☐severe) ☐ aversion to cold ☐cold limbs ☐cold lower back ☐cold abdomen ☐tidal fever ☐night fever ☐afternoon fever ☐mild fever ☐high fever ☐tidal fever ☐hot flashes ☐aversion to heat ☐aversion to wind ☐heat in the palms, soles and chest ☐alternating chills and fever ☐easily catch cold ☐no chills or fever	
Sweating	☐no sweating ☐profuse sweating ☐night sweating ☐spontaneous sweating ☐exhaustion sweating ☐sweating on the palms, feet and chest ☐normal	
Sleep	☐normal ☐easily fall asleep ☐insomnia ☐easy to wake up and difficult to fall asleep again ☐easy to wake up but easy to fall asleep again ☐shallow sleep with easily awakened	
Sleeping Hours: ____ / day	☐difficult to fall asleep when alone due to fear ☐dream disturbed sleep ☐excessive dreams ☐sleep walking ☐sleep talking ☐nightmares ☐seeing ghost ☐wake up to urinate ☐heavy feeling upon waking ☐somnolence (sleepiness during the day) ☐other:	
Head	☐vertigo ☐dizziness ☐edema or swelling ☐poor memory ☐heaviness ☐fainting ☐normal	
Headache	Location	☐frontal ☐occipital ☐vertex ☐both sides ☐sinusitis ☐no headache
	Quality	☐dull ☐sharp ☐moving ☐stabbing ☐fixed ☐burning ☐oppressing ☐heavy
Eyes	☐red eyes ☐dry eyes ☐bulging eyes ☐blurred vision ☐short-sightedness ☐night blindness ☐floaters ☐tearing ☐photophobia ☐pain ☐itching on eyelids ☐swelling ☐normal	
Ears	☐ringing in the ears ☐tinnitus ☐deafness ☐diminished hearing ☐normal	
Nose	☐nasal discharge (☐clear white ☐yellow sticky) ☐nasal congestion ☐rhinitis ☐flaring sensation ☐sneezing ☐normal	
Mouth/Lips	☐dry mouth ☐dry lips ☐ulcers ☐normal	
Throat	☐dry throat ☐sore throat ☐difficult to swallow ☐frequent clearing ☐feel something in the throat ☐normal	
Thirst	☐no thirst ☐thirst with desire to drink (☐warm drink ☐cold drink) ☐ thirst without desire to drink	
Appetite	☐poor ☐excessive ☐reduced recently ☐increased recently ☐no hunger ☐hunger without desire to eat ☐hunger even after overeating ☐normal	
Diet	☐irregular ☐regular ☐vegetarian	Crave for: ☐spicy ☐sweet ☐greasy ☐salty ☐raw ☐none
Digestion	☐nausea ☐vomiting ☐hiccup ☐belching ☐vomiting after eating ☐acid regurgitation ☐gas ☐normal ☐other:	
Taste	Taste in the mouth: ☐none ☐bitter ☐sweet ☐sour ☐salty ☐pungent ☐sticky sensation ☐lack of taste	
Chest	☐pain ☐oppression ☐palpitations ☐fullness ☐shortness of breath ☐wheezing ☐sighing ☐cough with(☐no sputum ☐ sputum difficult to expectorate ☐ sputum easy to expectorate ☐ blood-streaked sputum ☐ chest pain radiating to left shoulder, back and arm ☐other:	
Abdomen	☐pain worse on pressure or warmth ☐pain alleviated by pressure or warmth ☐fullness ☐distention ☐pain, distention or fullness on the lateral costal region (rib-side or below rib-side) ☐borborygmus ☐gas with flatus (farting)	
Back	☐upper back pain ☐lower back pain ☐soreness ☐coldness ☐other:	
Limbs	☐coldness ☐numbness ☐tingling ☐spasm ☐pain ☐edema ☐joint pain (see below) ☐tremor	
Joint pain	☐knee joint ☐elbow joint ☐moving pain ☐fixed pain with heavy sensation ☐hot, burning pain ☐pain alleviated by warmth ☐due to injury ☐other:	
Skin	☐itchy ☐dry ☐moist ☐edema ☐rashes ☐carbuncles ☐allergic ☐brittle nails ☐other:	

Urination and Bowel Movements				
Urination	Quality	☐frequent urination ☐hesitant urination ☐difficult to urinate ☐dribbling ☐incontinence ☐urgent urination ☐burning sensation on urination ☐painful urination ☐enuresis ☐bloody urination ☐stone ☐urinary blockage ☐normal		
	Amount	☐scanty ☐copious ☐normal	Frequency	_____ times / day
	Color	☐clear ☐dark yellow ☐milky ☐turbid ☐normal yellow		
Defecation & Bowel Movement	General	☐constipation ☐diarrhea (☐watery ☐foul-smelling ☐dawn) ☐dysentery ☐alternating constipation and diarrhea ☐normal		
	Quality	☐dry stools ☐hard stools ☐loose stools ☐undigested food in the stools ☐ stools with mucus ☐stools with pus ☐bloody stools ☐foul-smelling ☐normal		
	Shape	☐well formed ☐shapeless ☐thin stools ☐unsmooth ☐pencil-like stools ☐hard initial stools followed by loose stools		
	Condition	☐urgent defecation ☐tenesmus ☐fecal incontinence ☐difficult but successfully pass out ☐try to pass out with no result ☐burning sensation around the anus		
	Color	☐normal yellow ☐dark yellow ☐black tar-like ☐grayish white ☐other:		
	Frequency	_____ times / day or _____ times / week		

Emotions and Stress				
Fatigue	☐fatigued ☐sleepiness ☐heavy head and limbs ☐lassitude ☐fatigue with desire to lie down			
Emotion	☐normal ☐irritable ☐anxious ☐depressed ☐fearful ☐restless ☐prone to anger ☐mood swinging ☐manic tendencies ☐easy to cry ☐over-thinking ☐nervous			
Stress	Causes		Level	/10
Energy	Feeling		Level	/10

Female Condition							
Menstruation	Menarche Age		Date of last period		Duration (flow)		
	Intervals		Amount		Clots		
	Color		Contraception	☐Y ☐N	Menopause	☐Y ☐N	
	PMS		Other discomfort				
Pregnancy	☐Yes ☐No		Child Birth				
Leucorrhea	Color		Smell		Amount		

Male Condition
☐normal ☐seminal emission ☐impotence ☐unable to erect ☐premature ejaculation ☐nocturnal emission ☐nocturnal emission with dream ☐no sexual desire ☐excessive sexual desire ☐prostatic hypertrophy ☐other:
Life Style
☐on diet ☐exercise (times/week:_____) ☐smoking (cigarettes/day) ☐drug ☐meditation ☐yoga ☐alcoholic drinking (☐slight ☐heavy) Frequency of drinking (times/week) ☐other:
Other helpful information for your treatment

Thank you for your cooperation!