CHINESE MEDICINE PETERBOROUGH

308 Charlotte St.
Peterborough, ON, K9J 2V7
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Amy Lipsett, R.Ac, R.TCMP

Last Name	First Name	Date

Address	Phone (home)
City	Phone (cell)
Province	Phone (work)
Postal Code	Email
Date of Birth	Occupation

How did you hear about us? (Internet, friend, Doctor, magazine, sign etc.)

Reason for visit	Western medical diagnosis (if applicable)
When did symptoms first begin?	Are you currently being treated? Yes No
List other medical treatments received for this issue	Results of treatment
Family Physician Name	Physician Phone
Emergency Contact Name	Emergency Phone
List all prescriptions medications, over the counter drugs, supplements, herbs you currently take.	Reason for medication
1.	
2.	
3.	
4.	
5.	
6.	
List all allergies (food, drug, environmental etc.)	
1.	2.
3.	4.

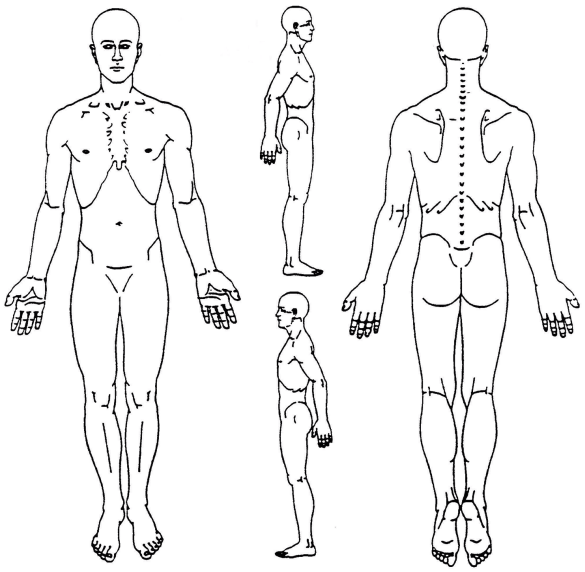
Health History (Please check the boxes that are applicable. Add dates and comments as necessary.)

	Heart Disease		Liver Disease		Kidney Disease		Lung Disease		Diabetes
	Stroke		Hepatitis		Hearing Issues		Asthma		Depression
	Blood Pressure Low / High		Headaches Migraines		Back Pain		Allergies		Bleeding Disorder
	Thyroid Issues Type:		Seizures		Osteoporosis		Skin Disease Type:		Chronic Fatigue
	Cancer (specify)		Digestive Issues		Urinary Issues (specify)		Arthritis (type)		Anemia
	HIV/AIDS		Tinnitus		Infertility		Shortness of Breath		Hemorrhoids
	Sexually Transmitted Disease		Prostate Issues		Impotence		Chronic Cough		Fibromyalgia
	Other (specify)								

Check all the symptoms that you have experienced in the past 12 months.

	Chest Pain		Irritability / Frustration		Memory Loss		Frequent Colds/ Flus		Fatigue
	Night Sweats		Vision Changes		Loss of Bladder Control		Sore Throat / Hoarseness		Bloating Gas
	Heart Palpitation		Numbness/Tingling limbs / hands / feet		Frequent Urination		Spontaneous Perspiration		Weight Gain Weight Loss
	Agitation/ Restlessness		Dry / Red / Itchy Eyes		Bladder Infection		Grief / Sadness		Bruise Easily
	Insomnia / Difficulty Falling Asleep		Premenstrual Syndrome		Intolerant to Cold		Constipation Difficult Bowel Movements		Unusual Bleeding
	Vivid Dream		Bitter Taste in Mouth		Low Back Pain Knee Pain		Skin Rashes Hives Skin Infections		Nausea Vomiting Heartburn
	Aversion to Heat		Weight Loss Weight Gain		Cold Hands Cold Feet		Snoring		Muscular Weakness
	Tongue or Mouth Ulcers		Dizziness		Sex Drive High Med Low		Cough Wet Dry		Appetite High Med Low
	Anxiety		Pain or Discomfort Under Ribcage		Feeling Fearful		Nasal Discharge		Tendency to Worry or Overthink

On the figures below, please circle any areas of concern/pain.



Type of Sensation/ Pain (check)

Cold_____ Tight_____

Sharp_____ Burning_____

Moving_____ Dull_____

Aching_____ Stabbing_____

Shooting_____ Throbbing_____

Tingling_____ Cramping_____

What makes the pain better?
(Rest, ice, heat, movement, etc)
_____
_____

What makes the pain worse? (Weather, heat, cold, movement, foods etc.)
_____
_____

Rate your pain level from 0-10 (10 being extreme pain).

0 1 2 3 4 5 6 7 8 9 10

Please list any past serious injuries, broken bones, surgeries, and procedures, including dates.

Daily Life Activities
Do you exercise? Yes___ No___ List type of exercise. How often?
Do you use the following? If so how often? Cigarettes_____ Alcohol _____ Drugs_____ Coffee_____ Pop_____
How well do you sleep? Circle on the scale of 1-10 (10 being best). 1 2 3 4 5 6 7 8 9 10
How is your daily energy level? 1 2 3 4 5 6 7 8 9 10
Rate your daily stress level. (10 being extremely stressed) 1 2 3 4 5 6 7 8 9 10

Gynecology- For Women Only	
Age of first menstruation:	Date of last menstruation:
Menstrual cycle length (i.e. 26-32 days)	How many days do you bleed in total?
Describe your flow: Heavy Average Light	Colour of the blood: (red, dark red, purple, brown, light red etc.)
Does the blood contain clots? Yes___ No___ If so, what size?(tiny, dime, nickel, quarter, loonie-size etc)	Do you experience menstrual pain? Yes___ No___ When? Before___ During___ After___ Describe the pain:
Do you experience pre-menstrual symptoms (PMS)? Describe:	Are you currently pregnant? Yes___ No___ How many times have you been pregnant?_____ Number of children? _____ Have you had any miscarriages? Yes___ No___ #____ Are you currently trying to get pregnant? Yes___ No___

Please check all boxes that apply to you.

	Vaginal Dryness		Vaginal Sores		Vaginal Discharge		PCOS (polycystic ovarian syndrome)		Pelvic Inflammatory Disease
	Ovarian Cysts		Endometriosis		Uterine Fibroids		Infertility		Irregular Periods
	Yeast Infections		Abnormal Pap Test		Prolapsed Uterus		Polyps		STD
	Fibrocystic Breasts		Painful Intercourse		Ectopic Pregnancy		Abortion		C-Section

For Fertility Patients Only (Male and Female). Answer the following questions if you're trying to conceive.

How long have you been trying to conceive?_____

Have you had a Western medical diagnosis relating to fertility? Yes___ No___

If yes, what was the diagnosis?_____

Has your partner (if applicable) had a Western medical diagnosis relating to fertility? Yes___ No___

If yes, what was the diagnosis?_____

Hormone Testing (Day 3, Day 21)

FSH	Low___	Normal___	High___
Estrogen	Low___	Normal___	High___
Progesterone	Low___	Normal___	High___
Prolactin	Low___	Normal___	High___
Thyroid (TSH)	Low___	Normal___	High___
Testosterone	Low___	Normal___	High___
Other:_____	Low___	Normal___	High___

For Fertility Patients (cont'd)

Have you undergone assisted reproductive treatments? (IUI, IVF, ICSI, etc.). Yes___ No___

Month/Year	Type of Treatment	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What was your medical response to fertility treatments? Poor___ Average___ Good___

Are you using donor sperm? Yes___ No___ Are you using donor eggs or embryos? Yes___ No___

Have you taken medication to help you ovulate? Yes___ No___

If yes, what kind?_____ For how many cycles?_____

Have you had any tubal operations? Yes___ No___

Have you had your uterus/fallopian tubes medically evaluated (HSG)? Yes___ No___

Results?_____

Male factors

Sperm Count (#/cc): _____ Sperm Motility (% moving): _____

Sperm Morphology: _____

Please indicate any other forms of past treatment, both conventional and alternative.

_____

_____

_____

_____

Patient Consent
I _____, consent to acupuncture and/or related treatments (tuina massage, cupping, moxabustion, herbal therapy, etc.) to be performed by an insured and regulated Acupuncturists/TCM Practitioner. I understand that all information shared, be it written or verbal will be kept strictly confidential. I have been informed that acupuncture is a safe method of treatment but that for some patients it may have some side effects such as bruising, numbness and tingling near the needling site, which may last a few days, dizziness and fainting. Infection is a rare risk, as the clinic uses sterile, single use, disposable needles and maintains a safe and clean environment. Unusual risks of acupuncture include nerve damage, organ puncture, including lung puncture. Burns are a potential risk of moxibustion and cupping. Please let your acupuncturist know if you are or become pregnant. By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have had the benefits and risks of acupuncture explained to me and have had the opportunity to ask questions. I understand that I am personally responsible for the payment of treatments provided when services are rendered and for any missed appointments if I fail to give 24 hour advance notice of cancellation. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.
Patient Signature: Date:
Guardian Signature (if applicable): Date:
Practitioner Signature: Date:

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