Karas Smith, R.TCMP
Registered Acupuncture & Traditional Chinese Medicine
133 Weber St. N., Waterloo, ON, N2J 3G9, 519-500-5668

Patient Health Summary

Patient Information		
First Name:	Last Name:	Middle Name:
Phone Number (home/mobile):	Telephone (business):	Sex: M / F / Other
Home Address:		Date of Birth: (DD/MM/YY)
City: Province: Postal Code:		Marital Status:
Occupation:	Email:	
Emergency Contact Information	**First Name:**	**Last Name:**
Relationship to Patient:	**Phone Number (home):**	**Phone Number (mobile):**
Family Doctor Name:		
Family Doctor Clinic Address:		
Family Doctor Phone Number:	Family Doctor Email:	

How did you hear about this clinic? _____

Have you received acupuncture before?: Yes No With whom?:_____

Current Health Concerns

Major Complaint(s), for which you are seeking treatment in order of significance to you:

1. _____ (date of onset):_____
2. _____ (date of onset): _____
3. _____ (date of onset): _____

Additional:_____

Pain scale of 1-10 (1 = minimal / 10 =extreme) 1 2 3 4 5 6 7 8 9 10

Describe your pain quality: _____

How does this condition impair your daily life or activities?_____

What other forms of treatment have you sought & with whom: _____

_____

On a scale of 1-10 how willing are you to change your habits to benefit your health? _____

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Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Diabetes	☐	☐	Jaundice	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Digestive Disorder	☐	☐	Kidney Disease	☐	☐	Thyroid (Hypo/Hyper)
☐	☐	Arthritis	☐	☐	Epilepsy/Seizures	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Mental Illness	☐	☐	Tuberculosis
☐	☐	Auto Immune	☐	☐	Heart Disease	☐	☐	Migraines	☐	☐	Vein Condition
☐	☐	Bleeding Disorder	☐	☐	Hepatitis : _____	☐	☐	Nerve Disorder	☐	☐	Venereal Disease
☐	☐	Cancer :_____	☐	☐	High Cholesterol	☐	☐	Pneumonia	☐	☐	Ulcers
☐	☐	COPD / Emphysema	☐	☐	HIV	Other: _____					
☐	☐	Depression	☐	☐	High/Low Blood Pressure						

Check if Yes : ☐ I have a pacemaker ☐ I am taking Coumadin/Warfarin ☐ I am taking Lithium

Do you have any Allergies? (food, drug, environmental) or adverse drug reactions: _____

_____

Significant traumas and dates (car accidents, sports injuries etc.):_____

_____

Hospitalizations/Surgeries (procedures and dates): _____

_____

Dental Procedures (include any silver fillings/mercury amalgams): _____

_____

Do you have a history of frequent antibiotic use? Please Describe: _____

_____

Do you get Allergy shots? ☐ Currently ☐ In the past ☐ Never

Please briefly describe your health as a child. (e.g. birth traumas, allergies/asthma, prone to illness, etc):

_____

Family Health History

Do any of your family members suffer from?	Whom:		
☐ Alcoholism	_____	☐ High Blood Pressure	_____
☐ Arteriosclerosis	_____	☐ Infectious Disease	_____
☐ Asthma	_____	☐ Mental Emotional Disorders	_____
☐ Cancer	_____	☐ Rheumatic Fever	_____
☐ Diabetes	_____	☐ Seizures	_____
☐ Heart Disease	_____	☐ Tuberculosis	_____
☐ Hepatitis	_____	☐ Other	_____

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Women's Health History

Are You Pregnant/ Could you be Pregnant? Yes No ***some acupuncture points cannot be used during pregnancy**

Do you have a Regular menstrual cycle? Yes No
Age of first menstruation:_____ Number of children: _____ Number of pregnancies: _____
Age of menopause (if applicable):_____ Number of abortions: _____ Number of miscarriages: _____

Length of Menstrual Cycle: ☐Short (Less than 28 days) ☐Long (28+ days) ☐Varied

Average number of days of flow: _____ Vaginal discharge: Yes No Bleeding between periods: Yes No

Pain with Periods? ☐ Before ☐During ☐After Clots with Period? Yes No _____

Are you on Birth Control ? Yes No Type:_____ For How Long?:_____

Do you experience any of the following Pre/Post Menstrual Symptoms?

☐Nausea	☐Vomiting	☐Water retention	☐ Breast swelling
☐Food cravings	☐ Headaches	☐Migraines	☐ Breast tenderness
☐Depression	☐ Irritability	☐ Anxiety	☐ Other emotions:_____
☐High Libido	☐ Low Libido	☐Dull pain where?_____	☐Sharp pain where?_____

Are you experiencing any low or high sexual desires?_____

Do you have any concerns surrounding this?_____

Do you have any other gynecological concerns or complaints?_____

Men's Health History

☐Prostate Problems	☐Testicular pain/swelling	☐Ejaculation problems
☐Low sex drive	☐Premature ejaculation	☐Erectile dysfunction/impotence
☐Nocturnal emission	☐Infertility	☐Difficulty maintaining erection
☐Low sperm count	☐Poor sperm motility	☐Irregular sperm morphology
☐Feeling of coldness or numbness of genitalia		☐Discharge _____

Do you have any other bothersome symptoms? Yes No Describe: _____

Do you get up at night to urinate? Yes No How often?_____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.) on a scale of 1-10 (1 = not at all, 5 = somewhat, 10 = completely): _____

What treatment have you tried for these problems and how successful have they been? _____

_____

_____

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TCM Symptom Profile

Please check any of the following symptoms that **currently** pertain to you.

Liver (Gan)
- ☐ Irritability/ Frustration/ Impatient
- ☐ Depression
- ☐ Easily stressed
- ☐ Joint stiffness
- ☐ Eye Floaters
- ☐ Blurred Vision/ Poor Night Vision
- ☐ Red/ Itchy/ Dry Eyes
- ☐ Dizziness
- ☐ Weak nails
- ☐ Headaches / Migraines
- ☐ Feeling of Lump in throat
- ☐ Muscle twitching/ spasms
- ☐ Neck/ Shoulder Tension
- ☐ Brittle Nails
- ☐ Sighing
- ☐ Rib/ Flank side pain
- ☐ PMS
- ☐ Rashes
- ☐ Genital Pain/ Itchy

Kidney (Shen)
- ☐ Frequent urination
- ☐ Bladder infections
- ☐ Lack of control (UB/GI)
- ☐ Wakes to urinate
- ☐ Feels cold easily
- ☐ Cold hands/ feet
- ☐ Early greying of hair
- ☐ Loss of head hair
- ☐ Low/ High Sex Drive
- ☐ Night sweats/ Hot Flashes
- ☐ Poor Hearing
- ☐ Craves salty foods
- ☐ Fearful
- ☐ Poor Memory
- ☐ Lower body Swelling (ankle/legs)
- ☐ Osteoporosis/Bone Issues
- ☐ Tinnitus (High/ Low)

Heart (Xin)
- ☐ Tongue/Mouth ulcers
- ☐ Palpations
- ☐ Chest Pain/ Tightness
- ☐ Insomnia / Sleep Issues
- ☐ Restless / Easily Agitated
- ☐ Anxiety
- ☐ Vivid Dreams
- ☐ Forgetful
- ☐ Aversion to Heat
- ☐ Bitter taste in mouth

Spleen (Pi)
- ☐ Heaviness in Head/Body
- ☐ Fatigue (AM/ PM)
- ☐ Water Retention
- ☐ Weak, Tired Muscle
- ☐ Bruises Easily
- ☐ Unusual Bleeding (nose,stool)
- ☐ Bad breath
- ☐ Poor appetite
- ☐ Increased appetite
- ☐ Craves sweets
- ☐ Poor Digestion
- ☐ Nausea/ Vomiting
- ☐ Bloating/Gas
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Loose Stool
- ☐ Alternate Constipation/Diarrhea
- ☐ Abdominal Pain
- ☐ Intestinal Pain/ Cramping
- ☐ Heartburn
- ☐ Over-Thinking/ Worrisome
- ☐ Foggy Mind
- ☐ Yeast Infection
- ☐ Aversion to Cold
- ☐ Cold Nose
- ☐ Increased Thirst
- ☐ Prefer Warm / Cold Drinks
- ☐ Sweats Easily

Lung (Fei)
- ☐ Dry Cough
- ☐ Cough w/ Phlegm
- ☐ Nasal Discharge
- ☐ Sinus Congestion
- ☐ Sore/Itchy Throat
- ☐ Dry Mouth/Nose
- ☐ Skin rashes/ Hives
- ☐ Snoring
- ☐ Sadness/ Grief
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Allergies
- ☐ Weak Immunity
- ☐ Fever / Chills

Lifestyle

How do you feel about the following areas in your life? Indicate any problems/stresses you may be experiencing:

	Great	Good	Fair	Poor	Bad	Comments
Energy Level						
Sleep						
Diet						
Work						
Family						
Significant Other						
Spirituality						

Soft drinks per day_____ Cups of coffee/ tea per day_____ Glasses of water per day:_____

Alcoholic beverages per week: _____ Tobacco use per week: _____ Recreational Drug Use: Yes No

Hours of Activity per week: _____ Type of Physical Activity:_____

Please describe your average daily diet:

Breakfast: _____

Lunch: _____

Dinner:_____

Snacks:_____ Foods you Crave: _____

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Please list all medications (prescribed and OTC)/ herbs/ vitamins and supplements which you are currently taking:

Type	Dose	Reason Prescribed	Date Prescribed	Prescribed by	Last Check up

By signing this form I consent that the information I have provided is accurate and true to the best of my knowledge.

Patient Signature:_____ Date:_____

Substitute Decision-maker: _____ Relationship to Patient: _____

Practitioner Signature:_____ Date: _____

Karas Smith, R.TCMP, ID# 4557

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Patient Informed Consent to Treatment Form

I, or the person listed below, have discussed with my traditional Chinese medicine practitioner or acupuncturist the specifics of my assessment or treatment and understand the nature, risks, and reasons for this procedure. I voluntarily consent to traditional Chinese medicine/acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under that scope of traditional Chinese medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, the electrical stimulation of needles, cupping, moxibustion, gua sha (dermal friction), tuina massage, nutritional guidelines, exercise techniques and stress management. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: mild pain, light-headedness or nausea, fainting, soreness, brief fatigue, sensations of heat or cold, tingling, numbness, bruising, bleeding or skin discolouration at the treatment area, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues including pregnancy, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese medicine does 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.
6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for traditional Chinese medicine treatments

Privacy Policy

I, _____ give consent to the collection, use and disclose of my patient information for the purpose of providing traditional Chinese medicine or acupuncture to me. I understand that there may be situations, in which the practitioner will have to collect, use or disclose personal health information without my consent, but that they will only do so if permitted by law.

Your personal information can be used or disclosed for the following reasons:

- To provide Traditional Chinese Medicine, acupuncture or massage services.
- To obtain payment for services provided
- To assist insurance companies with insurance claims verification
- To provide or arrange health care in cases of emergencies
- To seek advice for potential treatment options from another healthcare provider
- To fulfill any obligations as mandated by law or regulatory body

I understand that my personal health information is available for me to review except in limited circumstances as permitted by law. I also understand that I can ask to have my personal health information corrected anytime I believe there is a mistake in the records, with some exceptions. I understand that I can withdraw my consent at any time, but it may affect the services I can receive.

Patient Signature: _____ Date: _____

or Substitute-Decision Maker: _____ Relationship to Patient:_____

Practitioner Signature: _____ Date: _____

Karas Smith, R.TCMP, ID# 4557

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