Hannah Wang, R. TCM. P.

Acupuncture & Traditional Chinese Medicine

Consent and Information Form

Welcome to Hannah's Traditional Chinese Medicine Clinic I would like to take this opportunity to share some important information related to your treatment,

Traditional Chinese Medicine and Acupuncture very effective healing modalities which have been observed, practiced, and perfected over 3500 years in the system of medicine, the body has been mapped out in a series of pathways or meridians. Stimulation of specific locations along these meridians have proven to be very effective in treating a wide range of health imbalances. Recently, modern electromagnetic research has confirmed the specific locations. Acupuncture involves the insertion of fine sterile, disposable needles into these points. The needles themselves are of the highest quality and there are often no thicker than a human hair. As such, their insertion creates little or 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 effects to Acupuncture, British Columbia has extensive training and safety requirements for Acupuncturists and Traditional Chinese Medicine Practitioners as a result complications such as pneumothorax and nerve injury are extremely rare. We are, however required by law to advise you of those 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,Guasha, Fire-cupping, Moxibustion, Blood-letting, Tuina Massage as well as other treatment methods are commonly used in this Clinic. Guasha, Blood-letting & Fire-cupping will cause bruising.

All information related to your file will be kept confidential, The accompanying Comprehensive Health History is designed to determine how best to treat your health concerns, Please answer the best of your ability. It is my goal to provide a safe comfortable and effective environment for you 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

TCMP Hannah Wang New Patient Health History Form   Date:__________

1 Patient Information

Name: ______________________________
Address: ______________________________
City: ____________ Postal Code: ____________
Care Card #: ____________________
DOB: (M/D/Y) __/__/__ Age: __ Male/Female
Occupation: ____________________
Employer: ____________________
❑ Single ❑ Married ❑ Separated ❑ Widowed
Spouse's Name: ____________________
Do you have children? If so how many? ____
What are you seeking? ______________
❑ I have a disease injury or symptom and I am only interested in help with this specific problem
❑ I have a disease injury or symptom and I'm interested in help with this specific problem and learning how to prevent it from reoccurring in the future.

2 Contact Information

Home Phone: ______________________________
Work Phone: ______________________________
Cell Phone: ______________________________
Email: ______________________________

Emergency Contact

Name: ______________________________
Home Phone: ______________________________
Work Phone: ______________________________
Cell Phone: ______________________________

For reminder notices is the best way to contact me is:
❑ Text Message or ❑ Email
Cell phone provider: ____________________

3 Accident Information

Is this complaint related to an accident?
❑ Work ❑ Automobile ❑ Sports Team
If yes, report to front desk for additional forms.
To whom have you reported the accident?
❑ ICBC ❑ WCB ❑ Employer ❑ Other __________

4 Referral Information

How did you hear about our office?
❑ Friend/Family Member
❑ Through the Grape Vine
❑ Other: ______________________________

If referred whom may we thank for referring you to our clinic? ______________________________

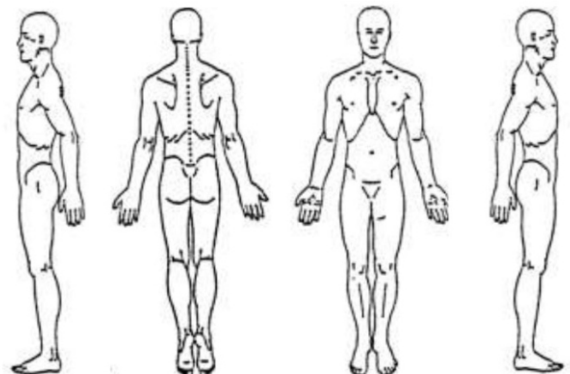
5 Current Patient Condition

Describe your main symptom(s) and area of injury or pain? ______________________________
When and how did your symptoms begin? ______________________________
Have you had this before? Explain: ______________________________
Is your condition getting progressively: ❑ Worse ❑ Better ❑ Staying Same
Is the symptom: ❑ Constant ❑ Comes and goes
My symptoms are worse in the: ❑ Morning ❑ Daytime ❑ Evening
How does it feel? ❑ Burning ❑ Sharp ❑ Stiff ❑ Ache
❑ Numbness ❑ Shooting ❑ Tingling ❑ Other: __________

What makes your symptom(s) worse? ______________________________
____
____

What makes your symptom(s) better? ______________________________
____
____

Please mark where it hurts



TCMP Hannah Wang New Patient Health History Form

6 Patient's Present Symptoms

Symptoms using a scale of 1 to 3 please note any symptoms you have had in the past year one being a mild occurrence to three being 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 Sweat
- ___ Lack of Sweat when Hot
- ___ Extreme Thirst
- ___ Thirst with No Desire to Drink
- ___ Edema or Swelling

Digestive:
- ___ Nausea
- ___ Vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Loose Stools
- ___ Bloody/Black Stools
- ___ Excessive Hunger
- ___ Hemorrhoids
- ___ Tired after Eating
- ___ Belching
- ___ Indigestion
- ___ Stomach Pain
- ___ Abdominal Bloating
- ___ Gas
- ___ Abdominal Pain
- ___ Acid Reflux

Skin:
- ___ Rashes
- ___ Hives
- ___ Dry skin
- ___ Oily skin
- ___ Acne
- ___ Easily Bruised
- ___ Skin feels Tight or Cracked
- ___ Dry or Brittle Nails

Eyes and Ears:
- ___ Decreased Vision
- ___ Blurred Vision
- ___ Visual Spots
- ___ Night Blindness
- ___ Eye Pain
- ___ Swelling
- ___ Red Itchy Eyes
- ___ Ringing in the Ears
- ___ Decreased Hearing
- ___ Ear Pain

Head and Neck:
- ___ Headaches
- ___ Muzzy or Heavy
- ___ Feeling in Head
- ___ Dizziness
- ___ Jaw Pain

Nervous System:
- ___ Fainting
- ___ Tremors
- ___ Poor Balance
- ___ Seizures
- ___ Numbness or
- ___ Tingling

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

Female:
- ___ Irregular periods
- ___ painful periods
- ___ Bleeding between periods
- ___ passing of clots
- ___ scanty period
- ___ early Period
- ___ No Period
- ___ Premenstrual
- ___ Grouchiness or Moodiness
- ___ Menopausal Symptoms
- ___ Breast Pain or Discharge
- ___ Vaginal Discharge

Heart Lung & Chest:
- ___ Palpitations
- ___ Chest Pain or Tightness
- ___ Irregular Heartbeat
- ___ Swelling of Ankles
- ___ Varicose Veins
- ___ Coughing up Blood
- ___ Shortness of Breath
- ___ Asthma/Wheezing
- ___ Frequent Colds
- ___ Sinus Congestion

Muscles and 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
- ___ Heavy Limbs
- ___ Swollen Joints

Male:
- ___ Premature Ejaculation
- ___ Impotence
- ___ Weak Urinary Stream
- ___ Prostate Hypertrophy

Mental/Emotional:
- ___ Difficulty
- ___ Concentrating
- ___ Poor Memory
- ___ Excessive Worry
- ___ Anxious
- ___ Depression
- ___ Easily Irritated
- ___ Fearfulness
- ___ Stress
- ___ Easy or Uncontrolled Excitability

Urinary/General:
- ___ Painful Urination
- ___ Difficult Urination
- ___ Frequent Daytime
- ___ Urination
- ___ Frequent night time Urination
- ___ Incontinence
- ___ Cloudy Urine
- ___ Bloody Urine
- ___ Genital Pain
- ___ Dryness/ Itch
- ___ Genital Discharge or Lesions
- ___ Low Libido

7 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 Disease
- ___ Chicken Pox
- ___ Chronic Cough
- ___ Chronic Pain
- ___ Diabetes
- ___ Eczema
- ___ Epilepsy
- ___ Fatigue Problem
- ___ Fibromyeligia
- ___ Glaucoma
- ___ Gallbladder Problem
- ___ Goiter
- ___ Gout
- ___ Heart Disease
- ___ Hepatitis
- ___ Hernia
- ___ Herpes
- ___ High Blood Pressure
- ___ High Cholesterol
- ___ Impotence
- ___ Intestinal Disorder
- ___ Insomnia
- ___ Liver Disease
- ___ Migraine/Headaches
- ___ Measles
- ___ Menstrual Disorder
- ___ Miscarriage
- ___ Multiple Sclerosis
- ___ Irritable Bowel
- ___ Kidney
- ___ Mumps
- ___ Prostate Problem
- ___ Psychiatric Care
- ___ Pacemaker
- ___ Pneumonia
- ___ Polio
- ___ Rheumatic Fever
- ___ Stroke
- ___ Stomach Disorder
- ___ Thyroid Disorder
- ___ Tuberculosis
- ___ Ulcers
- ___ Urinary Tract Infection
- ___ Vaginal Infection
- ___ Whiplash

TCMP Hannah Wang New Patient Health History Form

Please list any major Surgeries or Traumas:

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

Please list any Allergies in 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

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Cancellation and Fee Information

24 hours notice is required for all appointment cancellations
or there will be a fee charged as well as a fee charged for no shows

INSURANCE: We are not able to Bill WCB, MSP,
so payment is required at the time of treatment in these
circumstances. we do provide receipts for submission.

THIRD PARTY: Veterans, Department of National Defense
employees and RCMP require authorization and a doctor's referral
for us to bill directly, otherwise payment is due at the time of
treatment. Any missed appointment fees are the responsibility of
the patient.

I have read and agreed to the above:

____________________ ____________________
Signature Printed Name

____
Date