

Dr. Ann Zee R.Ac. DTCM  
Acupuncture/Traditional Chinese Medicine  
PATIENT INFORMATION

Date:		
Surname:		
First Name:	Middle Initial:	
Date of Birth (M/D/Y)	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:		
City:	Province:	Postal Code:
Family Doctor (Required):		
Business Employer:	Type of Work:	

Phone/Contact Information

Home:
Business:
Cell:
Email Address:

How were you referred to us?

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Please provide your reason for visit:


Have you consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought?  Yes  No

Physicians name:

What was their diagnosis?

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Please list any medications or nutritional substances you are currently taking:

Name of medication/supplement	Used for?	For how long?

**Personal History** Please check any conditions or symptoms that apply to you.

- Addiction(s)**                       **Aids**                                       **Anemia**
- Arthritis-Rheumatoid/Osteo**  **Asthma**                                       **Candida**
- Headaches**                               **Migraines**                                       **Chronic Pain Condition**
- Crohn's Disease**                       **Chronic Fatigue**                                       **Cholesterol**
- Common Allergies**                       **Diabetes I or II**                                       **Diverticulitis**
- Gastritis/Pancreatitis**                       **Heart Disease**                                       **Hepatitis**
- High/Low Blood Pressure**  **HIV +**                                       **Hives**
- Hypo/Hyperglycemia**                       **IBS**     **Impotence**
- Infertility**                                       **Insomnia**                                       **Kidney Issues**
- Liver/Gall Bladder Disease**  **Osteoporosis**                                       **Prostate**
- Seizures/Epilepsy**                       **Skin disorders**                                       **Stroke**
- TB**     **Thyroid Imbalance**                                       **Ulcer**

**Cancer: type** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Food Allergies/Intolerance** \_\_\_\_\_  
 **Other** \_\_\_\_\_

## Reproductive/ Gynecological

Birth control?

Age of first period?

Duration of period? (days)

Length of cycle? (days)

Are cycles regular?

Painful menses?

Heavy or excessive flow?

Clotting? Big or small clots?

Bleeding between cycles?

PMS?

Breast lumps?

Breast pain/tenderness?

Endometriosis?

Cervical Dysplasia?

Ovarian cysts?

Number of pregnancies?

Number of miscarriages?

Difficulty conceiving?

Menopausal symptoms?

Age of last menses? (if menopausal)

<p>1. During the day do you feel:  <input type="checkbox"/> chills    <input type="checkbox"/> fever    <input type="checkbox"/> both  <input type="checkbox"/> perspiration when not active</p> <p>2. Do you prefer to drink  <input type="checkbox"/> warm/hot fluids    <input type="checkbox"/> cold fluids</p> <p>3. Are you frequently thirsty?  <input type="checkbox"/> yes    <input type="checkbox"/> no    <input type="checkbox"/> sometimes</p> <p>4. How much water do you drink in a day?</p> <p>5. How is your appetite?  <input type="checkbox"/> good    <input type="checkbox"/> normal    <input type="checkbox"/> poor  <input type="checkbox"/> I experience “gnawing hunger”</p> <p>6. After eating do you experience?  <input type="checkbox"/> bloating    <input type="checkbox"/> gas    <input type="checkbox"/> acid regurgitation  <input type="checkbox"/> fatigue/sleepiness  <input type="checkbox"/> cravings for sweet/ salty</p> <p>7. At night, I:  <input type="checkbox"/> have difficulty falling asleep  <input type="checkbox"/> have difficulty staying asleep - if yes, what times are you waking?  <input type="checkbox"/> have dreams that wake me up  <input type="checkbox"/> wake feeling hot/sweaty  <input type="checkbox"/> feel anxious*  <input type="checkbox"/> have heart palpitations*  <i>*Please indicate if during the day too</i></p> <p>8. Urine:  <input type="checkbox"/> I wake during the night to urinate  <input type="checkbox"/> I urinate first thing when I awake  <input type="checkbox"/> unusual color    <input type="checkbox"/> unusual odor  <input type="checkbox"/> any mucus in your urine?  <input type="checkbox"/> any burning sensation?  <input type="checkbox"/> do you have frequent urination?  <input type="checkbox"/> have urgency to urinate?</p>	<p>9. Bowel Movements?  <input type="checkbox"/> constipated    <input type="checkbox"/> diarrhea    <input type="checkbox"/> both  <input type="checkbox"/> frequency  <input type="checkbox"/> unusual odor    <input type="checkbox"/> any mucus  <input type="checkbox"/> runny    <input type="checkbox"/> dry  <input type="checkbox"/> urgency to go first thing in the a.m.</p> <p>10. Pain? <i>Please describe if sharp, dull, achy, hot, cold, shooting, moving</i>  <input type="checkbox"/> in your back  <input type="checkbox"/> lower, middle, upper  <input type="checkbox"/> in your knees  <input type="checkbox"/> in your heels when you walk  <input type="checkbox"/> tension in your shoulders/neck  <input type="checkbox"/> headaches - what areas of head?  <input type="checkbox"/> migraines - caused by change in weather?  <input type="checkbox"/> Yes    <input type="checkbox"/> No  <input type="checkbox"/> shoulders  <input type="checkbox"/> arms  <input type="checkbox"/> hands  <input type="checkbox"/> legs  <input type="checkbox"/> feet  <input type="checkbox"/> other</p> <p>11. Hair/Teeth/Eyes?  <input type="checkbox"/> have you ever experienced hair/teeth loss?  <input type="checkbox"/> premature graying?  <input type="checkbox"/> do you grind/clench your teeth?  <input type="checkbox"/> do your eyes get dry, blurry, strained when tired?  <input type="checkbox"/> do you see ‘floaters’?</p> <p>12. Energy?  <input type="checkbox"/> are you frequently tired  <input type="checkbox"/> have normal levels  <input type="checkbox"/> better than normal</p> <p>13. Respiratory?  <input type="checkbox"/> any breathing difficulties</p>
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Office use only

PULSE R		PULSE L		TOUNGUE
LU		HT		
SP		LV		
KI YANG		KI YIN		

**Dr. Ann Zee, R.Ac.**  
**INFORMED CONSENT for Acupuncture &**  
**Traditional Chinese Medicine Therapy**

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of Traditional Chinese Medicine (TCM) on me (or the patient named below, for whom I am legally responsible) by Dr. Ann Zee, and/or other Alberta registered acupuncturists who may treat me now or in the future while associated with or referred to herein as the Acupuncturist.

I understand the methods of treatment may include, but are not limited to acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutrition counseling.

I have had the opportunity to discuss with the Acupuncturist named herein and/or with other office or clinical personnel, the nature and purpose of acupuncture and Traditional Chinese Medicine. I understand that results are not guaranteed.

I understand that there are some minor risks attendant to acupuncture treatment, including, but not limited to some slight bruising of the skin and/or slight bleeding. I understand that slight bruising is a common response to cupping and gua sha treatments. I will inform my Acupuncturist if I have any condition and/or taking any medication that interferes with blood clotting. I will notify my Acupuncturist if I have a pacemaker as electrical stimulation is contraindicated. I will notify my Acupuncturist should I become pregnant or if I am trying to become pregnant as certain acupuncture protocols are contraindicated (while other TCM treatments are favorable).

I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels, based on the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**About Your Treatment**

1. Sometimes, after receiving an acupuncture treatment, you may feel a little bit light headed. If that happens, please sit for a while in the waiting room. In a few minutes you will feel fine.
2. Herbal prescriptions and herbal patent medicines are intended only for the person for whom they were dispensed.

**Please sign and date below to indicate that you have read and understand this form.**

\_\_\_\_\_  
Patient Signature (or guardian, if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name