Chinese Medicine Confidential Patient Information

Name:	**Date of Birth:**	**Gender: male ☐ female ☐**
Address:	**State:**	**Post Code:**
Home Phone:	**Mobile:**	**Work:**
Emergency Contact (name & phone number) :		
Occupation:	**Referred By: Internet ☐ Friend ☐ Doctor ☐ Relative ☐ Other ☐**	
GP'S Name:	**Single ☐ Married ☐ Other ☐ Name :**	

Goals: what would you like to achieve with Chinese Medicine?	**Symptoms: list in order of Importance**	**Date of onset**
1.	1.	
2.	2	
3.	3.	
4.	4.	

Have you received a diagnosis for your concerns? If yes, what was the diagnosis?

Medications: list all Drugs	**Supplements: list all vitamins, minerals & herbal medicine**

Surgery History	**Date**	**Trauma History (accidents etc.)**	**Date**

What do you know about your birth (prolonged labour, forceps, premature, etc)?	**List all known allergies (food, chemicals, drugs, seasonal, insects, etc.)**

Check the Box ☒	Past	Current		Past	Current		Past	Current		Past	Current
General			**Sleep**			**Head, Ears, Eyes, Throat**					
Catch cold easily			Difficulty falling asleep			Headaches			Blocked nose		
Recurrent infections			Wake easily			Where:			Sinus infections		
Night sweats			Time per night?			When:			Jaw pain		
Bleed or bruise easily						Migraines			Teeth/ gum issues		
Organ prolapse			Wake up too early?			Dizziness/ vertigo			Recurrent sore throat		
Strong thirst			What time?			Fainting			Hoarseness/ loss of voice		
Fatigue/ low energy						Earache			Tonsillitis/ swollen		
Sudden energy drops			Nightmares			Change in hearing			Sores on lips/ mouth/ gums		
Weight change			Vivid dreams			Ringing in ears			Strange taste in mouth		
Skin			Grinding			Blurry vision			Swollen glands/ lumps		
Dry skin/scalp/hair			Talking in sleep			Night blindness			Oral ulcers		
Rashes/hives			Snoring			Colour blindness			Others		
Itching			**Circulation**			Spots before eyes			**Nervous System**		
Eczema			Cold hands or feet			Dry eyes			Loss of taste/ smell/ touch		
Warts			Swelling of hand or feet			Eye pain/ sore eyes			Tingling sensations/ numbness		
Acne			Blood clots			Excessive tearing			Tremors		
Change in moles			Varicose veins			Glasses/ contacts			Where?		
Hair loss/ thinning			Edema/ swollen ankles			Facial pain			Lack of coordination/ balance		
Greying			Puffy eyes			Facial paralysis			Paralysis/ seizures		
Other						Nosebleeds			Stroke		
									Concussion		
									Other		

Check the Box ☒	Past	Current		Past	Current		Past	Current		Past	Current
Respiratory			Constipation			Back Pain			Vaginal Discharge		
Chest Pain			Dry stools			Where			Vaginal dryness		

Tightness/ pressure			Not daily			Hand/wrist pain			Genital sores		
Pain breathing			Difficulty			Knee pain			Ovarian cysts		
Difficulty breathing			Alternating			Foot/ankle pain			Fibroids		
Shallow Breathing			Gas/ flatulence			Joint/bone problems			Endometriosis		
Shortness of breath			Anorexia nervosa			Muscle pain/weakness			Breast Lumps		
Chronic cough			Bulimia			Tremors/tics in muscles			Breast Swelling / redness		
Coughing Blood			Bad breath			Osteoporosis			Nipple discharge		
Coughing Phlegm			Other			Herniated disc			Abnormal pap smear		
Asthma/wheeze			**Urinary**			Where			Infertility		
Phlegm production			Pain on urination			Sciatica			Other		
high blood pressure			Urgent urination			Other			Are you pregnant now?		
Low blood pressure			Frequent urination			**Mind & Emotions**					
Palpitations/ rapid beat			Blood in urine			Poor memory			Is it possible you're pregnant		
Irregular heartbeat			Cloudy urine			Difficulty concentrating			Do you practice birth control?		
Other			Dribbling urination			Depression			What type and how long?		
Digestion			incontinence/retention			Often stressed					
Little appetite			Incontinence at night			Lose control of emotions			Number of pregnancies		
Strong appetite			Wake to urinate?			Substance abuse			Number of births		
Hunger but no desire			How many times?			Anxiety/nervousness			Number of premature births		
Food cravings						Manic behavior			Age of 1st menses		
Belching			Bladder/kidney infections			Panic attacks			Duration of menses		
Nausea			Yeast infections			Easily angered			1st day of last menses		
Vomiting			Kidney stones			Aggressive behavior			Number of days in cycle		
Heartburn			**Male Problems**			Other			Age of menopause		
Indigestion			Prostate			**Female Health**			Date of last pap		
Abdominal Pain			Change in sexual drive			PMS irritability					
Regurgitation			Rashes/itching			Clots in menstrual blood					
Weight loss			Genital discharge			Color of blood					
Weight gain			Erection difficulty			Irregular menses					
Loose stools/diarrhea			Low sperm count/motility			Painful menses					
Dysentery			**Muscles and joints**			heavy/ prolonged bleed					
strong smelling stools			Neck pain			Missed menses					
Blood in stools			Shoulder Pain			spotting/abnormal bleed					

Diet: example of a common day	**Lifestyle**	
Breakfast	Exercise: Hours per week:	Minutes per workout:
Snack	Type of Activity:	
Lunch	Relaxation: Hours per week:	Minutes per session:
Snack	Type of relaxation:	
Dinner	Work Hours:	
Snack	Home Hours:	
Caffeinated drinks per day: Alcohol per week:	Relationship: yes ☐ no ☐ Happy ☐ Unhappy ☐	
vegetarian yes ☐ no ☐ Meals per day:	Sex: Satisfied ☐ Unsatisfied ☐	Libido: High ☐ Low ☐

Additional Information

Cancellation Policy

Thank you for choosing to see Paul Carter for acupuncture/ herbal treatment. Please contact us at least 24 hours to cancel or reschedule your appointment. We often have patients on a waiting list and the more notice we have, the easier it is to make appointment times available to those who need them. We enforce a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if cancellation or rescheduling is less than 24 hours.

I _____ (please print name), have read the above policy and acknowledge that I will be charged the 50% of the service fee and am responsible for payment if I cancel or reschedule with less than 24 hours' notice.

Signed (patient signature): _____

Date: _____

INFORMED CONSENT

I hereby voluntarily consent to be treated with Chinese Medicine by Paul Carter, an acupuncturist and herbalist. I understand that treatment may involve the modalities of acupuncture, moxibustion, herbal medicine, nutritional advice, and lifestyle counselling consistent with the principles of Chinese medicine.

I understand that Paul Carter performs treatments with the insertion of acupuncture needles through the skin, or by the application of heat to the skin, or by both in an attempt to support the body's physiological functions. I understand the needles used are sterile, single use disposable needles. I understand that all of my patient records as well as information I share with Paul will be kept confidential. No records or information will be released without my written consent.

While acupuncture is generally a safe method of treatment, I am aware that certain side effects may result. These could include, but are not limited to, some local bruising, bleeding, dizziness, fainting, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days and temporary aggravation of symptoms in existence prior to treatment. I also understand that Chinese medicine is not primary care medicine and that if my symptoms worsen, new symptoms arise, or I have any concerning change in my health status I should consult a licensed medical doctor.

I understand that I should inform Paul Carter prior to being treated if I believe I might be pregnant. I understand that no guarantees concerning acupuncture's use and effects are given to me, and that I am free to stop acupuncture treatment at any time. None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate. I have carefully read and understand all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

PATIENTS NAME	**DATE**
PATIENTS SIGNATURE (or patients representative)	
PATIENT REPRESENTATIVE NAME	