Vital Acupuncture & Massage

INITIAL CONSULTATION – CONFIDENTIAL

NAME_____ D.O.B. _____

ADDRESS _____

_____State: _____ Post Code _____

TELEPHONE (H) _____ (W) _____ (M) _____

EMAIL _____ OCCUPATION _____

Can we leave a message if you are not available? Yes No

How did you hear about us? ☐ Doctor ☐ Drive-by ☐ Yellow Pages ☐ Gift ☐ Social Media

☐ Neighbourhood Newsletter ☐ Internet Search ☐ Other _____

Would you like to receive a text message about specials ☐ Yes ☐ No

Emergency Contact

Name _____ Phone _____ Relationship_____

Medical Details

Health Fund: _____

Name of Doctor: _____ Telephone: _____

Name of Other Health Care Professional treating you:

Are you Pregnant? ☐ Yes ☐ No Weeks pregnant: _____ Any high risk factors?

Do you have Botox? ☐ Yes ☐ No Date of Injection ___ /___ / ___ Body Location _____

Please List ALL types of Surgeries you have had in the past (Please Include Dates): _____

_____

_____

Please List ALL Accidents and/or Hospitalizations you have had in the past (Please Include Dates): _____

_____

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Please List ALL Allergies (Food, Medications, Pollen, etc:

_____

List ALL Medications (prescription & over-the-counter, Vitamins & Supplements, Herbs) you are CURRENTLY taking (Please include duration of use & Dosage):

_____

_____

Imaging & Test	Dates	Results & Area that was imaged
X-ray (s)		
MRI (s)		
CT Scan (s)		
Ultrasound (s)		
Mammogram		
PAP Smear		
Nerve Conduction		
Blood Tests		
Blood Sugar		
Cholesterol		LDL HDL

Please indicate any of the following that apply to you.

☐ Aids/HIV	☐ Cancer	☐ High Velocity Injuries	☐ Parkinson's
☐ Allergies	☐ Chest Pain	☐ High Blood Pressure	☐ Renal Disease
☐ Anxiety	☐ Diabetes	☐ Low Blood Pressure	☐ Swelling
☐ Anaemia	☐ Dizziness	☐ Joint Replacement(s)	☐ Skin Disorders
☐ Arthritis	☐ Depression	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Lung Disease	☐ Sprains or Strains
☐ Autoimmune Disorders	☐ Fainting	☐ Muscle Pain	☐ Tuberculosis
☐ Bladder Disease	☐ Fractures	☐ Neck Pain	☐ Tingling / Burning
☐ Bleeding Disorders	☐ Gall Bladder Disease	☐ Numbness	☐ Varicose Veins/DVT
☐ Blood Clots	☐ Heart Disease	☐ Osteoporosis	
☐ Back Pain	☐ Hepatitis	☐ Palpitations	
☐ Bell's Palsy	☐ Headaches	☐ Paralysis	

MAIN COMPLAINTS	Intensity	
Presenting Conditions and/or Health Conditions you would like to have help addressing. (Please list in the order of importance below)	On a scale of "1 to 10", please rate the intensity of your complaint **(0 + No Discomfort, 10 + extreme discomfort)**	
	On **AVERAGE** your complaint is	At **WORST** your complaint is
1.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

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Onset		What have you tried doing to resolve these problems that DID NOT work?
For each condition listed above, please mark when it first began, or when you started experiencing them?		The definition of "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or the treatment did not restore your body's own ability heal itself.
1	Date Began:	
2	Date Began:	
3	Date Began:	
4	Date Began:	

	Frequency	Duration
	Please check the box that best represents how frequent you feel your chief complaint(s)	When you are feeling your symptoms, how long do you symptoms last?
1	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month	❑mins ❑hours ❑days ❑constant
2	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month	❑mins ❑hours ❑days ❑constant
3	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month	❑mins ❑hours ❑days ❑constant
4	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month	❑mins ❑hours ❑days ❑constant

What AGGRAVATES or ALLEVIATES your chief complaints?

	What **AGGRAVATES** each of the complaints above?	What **ALLEVIATES** each of the complaints above?
1		
2		
3		
4		

How are your health problems interfering with the following areas of your life?

Work	
Family	
Sports & Hobbies	
Life	

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Have you had or are you currently having:

☐ Injections ☐ Acupuncture ☐ Chiro/Osteo ☐ Massage ☐ Physiotherapy ☐ Dry Needling

Other: _____

How did the previous methods work for you? _____

ARE YOU HERE VISITING US, BECAUSE YOU: (please choose one)

a) Just want to get some Relief from your symptoms, and then you'll manage the rest with medication

b) Want to Find & Correct the Root Cause of your Health problem(s), if possible, and Start a Lifestyle program for optimized living where your body can heal itself without medications or be less dependent upon medications.

c) Other:_____

If we were to sit down and discuss your life 1 year from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short!)

_____

_____

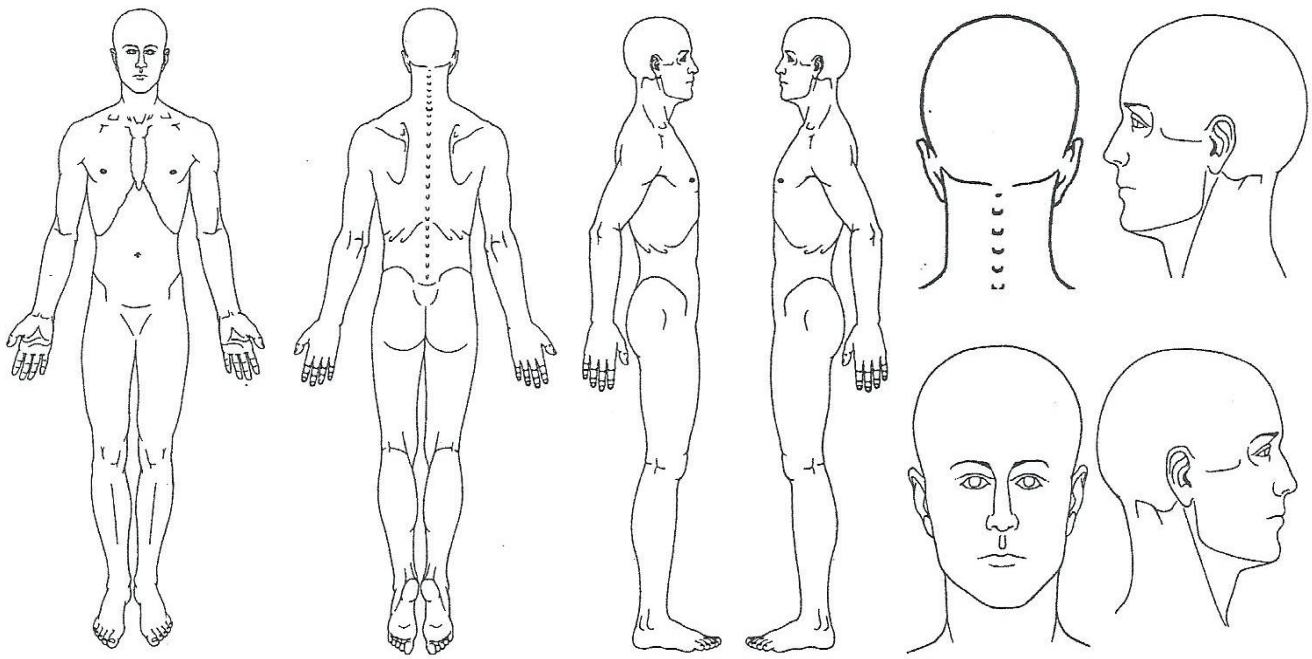
Do your work activities mostly involve: Sitting / Standing / Light Labor / Heavy Labor

What is your daily / weekly intake of the following:

Caffeine _____ Alcohol _____ Nicotine/Tobacco _____ Recreational Drugs: _____

Additional Patient Notes or Questions _____

Please Indicate Areas of Pain



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Traditional Chinese Medicine Questions

LUNG / LARGE INTESTINE System Function

☐ Shortness of Breath
☐ Wheezing
☐ Difficulty Breathing
☐ Heaviness in chest
☐ Asthma
☐ Easily catch colds
☐ Chronic Infections
☐ Nasal / Sinus Problems
☐ Nose Bleeds
☐ Cough (dry / productive / blood / persistent)
☐ Snoring
☐ Loss of Smell / Loss of Taste
☐ Dry Nose / Dry Mouth
☐ Dry / Sore Throat
☐ Dry Skin
☐ Allergies / Sneezing
☐ Alternating fever & chills
☐ Excessive Sweating
☐ Difficult Sweating
☐ Headaches
☐ Stiff Neck & Shoulders
☐ Chronic sadness
☐ Constipation / Difficult Defecation
☐ Haemorrhoids / Blood / Mucous in Stools

SPLEEN System Function

☐ Low appetite
☐Fatigue after eating
☐ Loose stools / Diarrhea
☐ Undigested food in stool
☐ Abrupt Weight Gain
☐ Abrupt Weight Loss
☐ Abdominal Bloating / Gas
☐ Borborygmus / Gurgling noise in stomach
☐ Bleeding, swollen/painful gums
☐ Heartburn / Acid Regurgitation
☐ Nausea / Vomiting
☐ Frequent Belching / hiccups
☐ Frequent / Constant Hunger
☐ Stomach pain
☐ Bad breath
☐ Canker sores in the mouth
☐ Bruise easily
☐ Always worrying / over-thinking everything
☐ Weak / Atrophy in muscles
☐ Whole body feels heavy
☐ Fluid retention (Oedema, heavy limbs & body)
☐ Swollen feet / Legs / Joints
☐ Sighing
☐ Yawning

HEART System Function

☐ Anxiety / Restlessness
☐ Sores on tip of Tongue
☐ Speech problems
☐ Trouble falling / Staying asleep
☐ Waking up during the night
☐ Waking up unrefreshed
☐ Inability to focus (ADD, ADHD)
☐ Frequent Dreams
☐ Mental Sluggishness
☐ Tired
☐ Chest Pain traveling to shoulder
☐ Irregular Heart Beat
☐ Fast heart beat (>100 beats/min)
☐ Slow heart beat (< 50 beats/min)
☐ Palpitations / Fluttering

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LIVER / GALL BLADDER System Function

☐ Alternating Diarrhea & Constipation
☐ Tight sensation in the chest
☐ Bitter taste in the mouth
☐ Irritable frequently
☐ Angry frequently
☐ Frustrated frequently
☐ Mood Swings
☐ Suffering from Depression
☐ Skin Rashes (Red or Itchy)
☐ Headaches
☐ Numbness / Tingling Sensation
☐ Muscle Twitching / Cramps / Spasms
☐ Seizures / Convulsions
☐ Tremors
☐ Tics
☐ Lump in the throat
☐ Neck and Shoulder Tension / Tightness / Pain
☐ Joint Pain
☐ TMJ Pain
☐ Clenching Jaw/ Teeth Grinding
☐ High-Pitched ringing in ears
☐ Difficulty adapting to stress
☐ Dizziness / Poor Balance / Vertigo

EYES / VISION

☐ Itchy Eyes ☐ Blood Shot Eyes
☐ Burning Eyes ☐ Blurry Vision
☐ Dry Eyes / Watery Eyes / Gritty Eyes
☐ Decreased Nigh Vision
☐ Floaters

KIDNEY / BLADDER System Function

☐ Cold Hands and Feet
☐ Feels cold all the time (whole body)
☐ Hot Flashes
☐ Night Sweats
☐ Thirsty all the time
☐ Frequent cavities ? Teeth problems
☐ Sore Achy & Weak Knees
☐ Lower Back Pain
☐ Memory Problems Short Term / Long Term
☐ Excessive hair loss /Premature greying of hair
☐ Low-pitched ringing in the ears
☐ Poor Hearing / Hearing Problems

URINATION

☐ Lack of bladder control (Incontinence)
☐ Wake during the night (>1 time per night)
☐ Scanty Urination
☐ Profuse Urination
☐ Frequent Urination
☐ Urgency to urinate
☐ Difficult / Incomplete urination
☐ Painful / Burning urination
☐ Cloudy Urine
☐ Reddish urine
☐ history of chronic fear
☐ Easily startled
☐ General Weakness, low energy, chronic fatigue
☐ Low or No Libido
☐ Excessively high libido

FOR WOMEN ONLY

☐ Length of Cycle _____ days
☐ Duration _____ days
☐ Date last period began _____ /____ /_____
☐ Heavy / Light
☐ PMS
☐ Pre-menstrual Lower Back Pain
☐ Clots Size 5 / 10 / 20 / 50 cent piece / Larger
☐ Pain
☐ Cramps
☐ Number of Pregnancies _____
☐ Menopause _____ year
☐ Odour
☐ HRT
☐ Infertility
☐ IVF _____year
☐ Endometriosis ☐ PCOS

FOR MEN ONLY

☐ Swollen testes
☐ Testicular Pain
☐ Inability to maintain erection
☐ Premature ejaculation

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IMPORTANT: Complete these documents as thoroughly as possible, please be honest with yourself. Some of the questions that follow may seem unrelated to your condition, BUT they may play a major role in diagnosis and treatment. **All information is strictly confidential**.

Cancelation Policy

A **minimum of 24 hours' notice** is required if you need **to cancel or re-schedule** your appointment, otherwise a cancellation fee of a 100% applies.

Informed Consent Declaration

I declare that all the information disclosed on medical history and medications is correct and I give consent for treatment. If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I understand that methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, Gua Sha, Electrical stimulation, Remedial Massage, Sports Massage, Chinese Herbal Medicine services. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be of an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, dizziness or fainting, numbness or tingling near the needling sites that may last a few days. Burns and/or scarring are a potential risk of moxibustion, cupping and heat lamps. Bruising is a common side effect of cupping and Gua Sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax) or Infection, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant or experience any side effects immediately.

Patient Signature: _____Date: ____ /____ /_____

Patient Name: _____

Parent or Legal Guardian
(if under 18) printed name: _____

Parent or Legal Guardian

Signature: _____Date: ____ /____ /_____