

General Information

SURNAME	GIVEN NAME	DATE OF BIRTH (YYYY/MM/DD)
ADDRESS APT , NO. AND STREET / CITY, PROVINCE / POSTAL CODE		
PHONE NUMBER	EMAIL	REFERRED BY

When you make an appointment at this clinic, that timeslot is reserved just for you. Out of respect for you and your time, my clinic runs on schedule and for that hour you have my undivided attention and care. Thus out of respect for my time I require 24 hours notice for any cancellations or changes. Cancellations without notice will result in a full treatment fee of \$75.

When performed by a competently trained licensed professional, acupuncture is extremely safe. At this clinic, I use only sterile, single-use disposable needles, thus there is virtually no chance of infection or contagion. Some minor side effects of acupuncture may include bruising, achiness at one or two sights, and drowsiness after the first treatment. Occasionally there may be major side effects. Although it is extremely rare, some cases have been reported. These include perforation of an internal organ, nerve damage, or pneumothorax. Again, these reports are extremely rare. Please feel free to ask any questions about the proposed treatment.

Declaration:

I have read and understood the above information and agree to have Bronwyn Melville, TCM.P. perform acupuncture and Traditional Chinese Medicine on me.

I also agree to allow Bronwyn to discuss relevant aspects of my condition with my other health care providers, namely my Physician, Midwife, Massage therapist, ect. I understand this consent is voluntary and I may revoke my permission at anytime.

SIGNATURE	DATE
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Health History

WHAT CHIEF COMPLAINTS WOULD YOU LIKE TO ADDRESS?	HOW LONG HAVE YOU HAD THIS PROBLEM?
WHAT IS YOUR PHYSICIAN'S DIAGNOSIS?	WHAT OTHER TREATMENTS HAVE YOU TRIED?
DO YOU TEND TO FEEL HOT / COLD?	DO YOU EXPERIENCE FLASHES OF HEAT OR CHILLS? IF SO, WHAT TIME OF DAY TYPICALLY?
DO YOU CRAVE WARM OR ICED BEVERAGES? IF SO, HOW OFTEN?	HOW MUCH WATER DO YOU DRINK IN A DAY?
DO YOU SWEAT SPONTANEOUSLY FOR NO APPARENT REASON? (IE WHILE RELAXING/RESTING)	DO YOU SWEAT AT NIGHT? HAVE YOU WOKEN UP SOAKED IN SWEAT?
ON A SCALE OF 1-10 RATE YOUR DAILY ENERGY LEVEL WHAT TIMES OF DAY ARE WORSE? WHAT TIMES ARE BEST?	HOW MANY BOWEL MOVEMENTS PER DAY? WEEK? ARE THEY FORMED, LOOSE, DIFFICULT? ANY UNDIGESTED FOOD? MUCUS? BLOOD? HEMORRHOIDS?
DO YOU EXPERIENCE URINARY FREQUENCY, URGENCY, BURNING, DRIBBLING OR RETENTION? WHAT SHADE OF YELLOW IS IT? ARE YOU SUSCEPTIBLE TO INFECTIONS?	LIST HERE WHAT YOU ATE YESTERDAY. MORNING: AFTERNOON: EVENING: NIGHTTIME:
DO YOU HAVE DIFFICULTY FALLING ASLEEP? DO YOU WAKE UNABLE TO FALL BACK ASLEEP?	DO YOU HAVE VIVID DREAMS? HOW OFTEN? ABOUT WHAT? DO YOU HAVE DIZZINESS?

Women's Health

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST PERIOD?	HOW MANY DAYS DO YOU BLEED?
	HOW LONG IS THE CYCLE (IE 28 DAYS)
DESCRIBE YOUR MENSTRUAL BLOOD. CHECK ALL THAT APPLY: <input type="checkbox"/> BRIGHT <input type="checkbox"/> PALE <input type="checkbox"/> THIN <input type="checkbox"/> THICK <input type="checkbox"/> CLOTTED <input type="checkbox"/> RED <input type="checkbox"/> PURPLISH <input type="checkbox"/> BROWN	DESCRIBE YOUR FLOW. HEAVY / SCANTY ON WHICH DAYS?
WHAT ACCOMPANYING SYMPTOMS DO YOU HAVE BEFORE YOUR PERIOD? CHECK ALL THAT APPLY: <input type="checkbox"/> CRAMPING <input type="checkbox"/> WEEPNESNESS <input type="checkbox"/> INSOMNIA <input type="checkbox"/> IRRITABILITY <input type="checkbox"/> EXHAUSTION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> ANGER <input type="checkbox"/> BREAST TENDERNESS	DESCRIBE ANY SYMPTOMS THAT COME AFTER YOUR PERIOD?

Organ Systems Review

In Traditional Chinese Medicine, an organ does not necessarily refer to the anatomical structure at a set location. When we talk about the Liver, for example, we mean not the actual Liver, but rather a set of processes associated with its role in Traditional theory. The following is a list of typical symptoms within that system.

PLEASE RATE YOUR CURRENT EXPERIENCE OF EACH SYMPTOM ON A SCALE OF 1-5 (5 BEING THE WORST):

LIVER _____ IRRITABILITY/FRUSTRATION _____ DEPRESSION _____ POOR NIGHT VISION _____ FLOATERS/BLURRED VISION _____ RED, DRY, OR ITCHY EYES _____ HEADACHES/MIGRAINES _____ DIZZINESS _____ SENSATION OF A LUMP IN THROAT _____ BRITTLE NAILS _____ SIGHING _____ GENITAL ITCHING/PAIN/RASHES _____ BITTER TASTE IN MOUTH HEART _____ PALPITATIONS _____ CHEST PAIN/TIGHTNESS _____ INSOMNIA/SLEEP PROBLEMS _____ RESTLESS/EASILY STARTLED _____ VIVID DREAMS _____ TONGUE/MOUTH ULCERS/CANKERS	LUNGS _____ DRY COUGH _____ COUGH WITH PHLEGM _____ NASAL DISCHARGE/DRIP _____ SINUS INFECTION/CONGESTION _____ DRY MOUTH/THROAT/NOSE _____ SKIN RASHES/ECZEMA _____ SHORTNESS OF BREATH _____ ALLERGIES/ASTHMA _____ SUSCEPTIBILITY TO COLD/FLU KIDNEYS _____ FREQUENT URINATION _____ URGENT URINATION _____ BLADDER INFECTIONS _____ WAKE TO URINATE _____ LOW LIBIDO _____ HIGH LIBIDO _____ HEARING PROBLEMS _____ TINNITUS _____ POOR LONG TERM MEMORY	_____ ANKLE SWELLING _____ CRAVE SALTY FOODS SPLEEN _____ HEAVY SENSATION/FATIGUE _____ WATER RETENTION _____ MUSCULAR WEAKNESS _____ BRUISE EASILY _____ POOR APPETITE _____ INCREASED APPETITE _____ CRAVE SWEETS _____ NAUSEA/VOMITING _____ BLOATING/GAS _____ HEMORRHOIDS _____ CONSTIPATION _____ LOOSE STOOL _____ ABDOMINAL PAIN/CRAMP _____ OVERWEIGHT _____ FOGGY MIND _____ YEAST INFECTIONS
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