Name: _____ Date: _____

Address:_____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Cell:_____E-mail:_____

Date of Birth: _____Occupation:_____

How did you hear about our office? Please identify:

□ Health care practitioner's referral □Internet □Friends □Card/Flyer □Other:_____

Chief Compliant: _____

How long have you had it: _____ Medical Diagnosis: _____

Are you on any medication? (Please give details: Name, Dosage, Frequency, Duration)

_____

Have you had any surgery? _____

Have you received the following alternative medical services (Please check):

□Acupuncture □ Chinese Herbs □ Moxibustion □ Cupping / Scraping

GENERAL CONDITION and FAMILY HISTORY:

Use "*" for self, "F" for father, "M" for mother, "S" for siblings, "G" for grandparents

___Diabetes ___Heart Disease ___Seizures ___Stroke ___Mental Illness

___Asthma ___High / Low Blood Pressure ___ Arthritis ___ Alcoholism

___ Gallbladder problems ___ Liver problems ___ Kidney problems

___Cancer: _____ ___ Allergies:_____

Others: _____

On a scale of 1-10, what is your stress level? _____

Generally speaking, do you prefer **cold** or **warm** drink and food?_____

Sleeping:___ hours a day from ____ to ____, □ Hard to fall asleep □ Frequent dreams □ Wake up easily

Vegetarian? _____ Vegan? _____ How many years? _____

Food allergies or restrictions: _____

Raw foods % in diet _____ Frequency of consumption of the following:

Dairy: _____ Cola/pop: _____ Eggs:_____ Caffeine:_____

Salt: _____ Alcohol: _____ Cigarettes/Nicotine : _____ _____

Do you have cravings? Yes, explain:_____

Take herbal and/or nutritional supplements? Please list:

_____

Do you have, or are you a carrier of an infectious or transmitted disease (eg. HBV / HIV / AIDS)? If yes, please specify:_____

OTHER SYMPTOMS Do you presently have or have you had any of the following conditions? If in the past, how long ago? (Please check)

□ Sweat easily	□ Night sweating	□ Anger easily	□ Low energy	□ Short of breath
□ Sore throat	□ Headache	□ Migraines	□ Oedema	□ Dizziness / Vertigo
□ Dry eyes	□ Eye floaters	□ Ringing in ears	□ Loss of hearing	□ Grinding Teeth
□ Sinus problem	□ Phlegm	□ Chronic cough	□ Chest pain / stuffiness / tightness	
□ Poor Memory	□ Belching	□ Bad breath	□ Nausea / Vomiting	
□ Constipation	□ Abdominal pain	□ Heart Burn	□ Diarrhoea/Lose Stool	
□ Haemorrhoids	□ Gas/Bloating	□ Alcoholism	□ Blood in urine	
□ Thirsty but no desire to drink		□ Prostate problem	□ Urination problem	
□ Impotence / Lack of sex drive / Infertility			□ Other kidney problems	
□ Cold hands and/or feet			□ Heaviness in the whole body	

Genitourinary (for female only)

□ Painful menstruation (period)	□ Clots in blood	□ Irregular periods	□ Breast lumps
□ Heavy / Light period	□ PMS	□ Menopause	□ Unusual vaginal discharge
□ Miscarriage	□ Others (please specify):_____ _____		

IMPORTANT

Are you currently pregnant or even think that you might be **pregnant**? _____

Are you wearing any **embedded electronic devices**?_____

Do you have **bleeding disorders** or are taking **blood thinning or anticoagulant medicine**?

Do you have breast or other **implants**?_____

Information and Consent Form

for Acupuncture and other Chinese Medical Modalities

Things are important to ensure your acupuncture treatment results:

- Avoid being over-hungry, overeating or eating any foods that cause your stomach to be upset (for example, cold, rich, greasy, fried, or spicy food);
- Avoid alcohol on the day of treatment;
- Do not become intoxicated before or shortly after treatment;
- Avoid heavy exertion (including sexual activity) immediately before and after treatment (i.e. within 2 hrs);
- Set aside enough time so that you are not rushing to and from your visit. (i.e., do not schedule your appointment for an hour before your 2 hour kick-boxing class);
- Wear loose, comfortable clothing that can be rolled up to your elbows or knees.

The most common minor ill effects of Acupuncture if they occur are:

- Minor bleeding or bruises, post-acupuncture sensation (numbness, tingling, heaviness and tiredness, nausea), or mild local pain at a few needle sites or treatment areas with cupping and Scraping;
- Temporary aggravation of symptoms;
- Occasionally patients may feel a little faint especially on the first treatment, and this is related to apprehension and fear;
- A feeling of wooziness, drowsiness especially on the first or second treatments can occur, particularly when strong electrical stimulation is used;

You are advised **NOT TO DRIVE ON THE FIRST VISIT**, but to have a family member or a friend drive you home after the first treatment.

- Burns and/or scarring are a potential risk of moxibustion and cupping.

I, the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture and Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by R.Ac Toby Li.

I understand that methods of treatment are given by Toby Li may include, but are not limited to: acupuncture, moxibustion, cupping, scraping, electrical stimulation, nutritional and life style counseling, and recognize:

- That it is most advisable to discuss this with my medical physician prior to the treatment.

- That if I am undergoing any current treatment by my medical physician that this treatment should be referred to the physician prior to undertaking same.

- That these treatments are done after full consideration, discussion and with the advice of my physician (or waiving advice of such physician).

- That while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinic staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand that all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above information and consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I shall also take full responsibility for any possible adverse affects resulting from the treatments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) or which I seek treatment.

Please print your name: _____

Signature: _____ Date: _____