



Dr. Mee Lain Ling

Dr.TCM, M.A. (Ed), B.Ed.

nurturing your vibrant health

CLIENT CONSULTATION FORM (Confidential)

Today's Date: DD / MM / YY

FIRST NAME	LAST NAME	DATE OF BIRTH	AGE
Address _____		City _____	Postal Code _____
Phone (Home) _____	(Cell) _____	Occupation _____	
Emergency Contact _____		Phone _____	
Email _____	Had acupuncture or Chinese medicine before?		YES NO

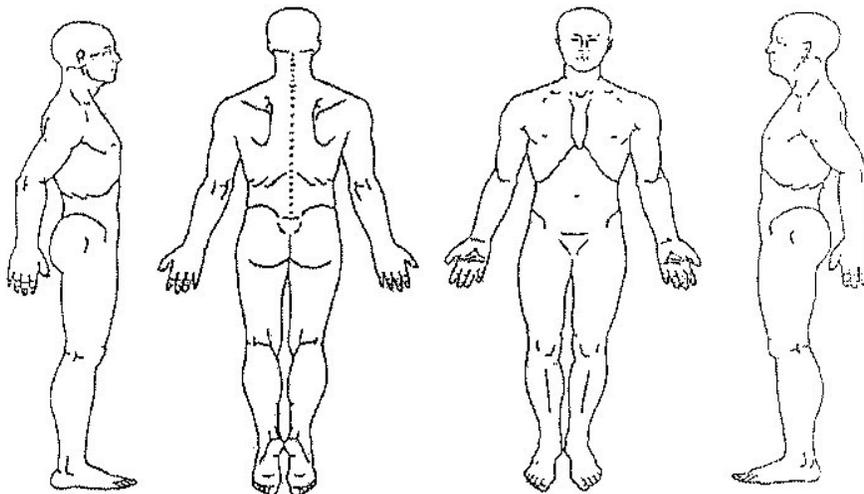
Reason(s) for Today's Visit: _____

Your family physician's diagnosis: _____

Do you have any objections to your family physician being contacted about the progress of your condition? Yes No

Name of Family Physician: _____ Phone: _____

On the diagram(s) below, please circle the area(s) that applies most to where you experience pain or discomfort.



Use these letters to describe the pain: **S** sharp **D** dull **A** achy **N** numb **T** tingling **H** hot **C** cold **DB** deep & boring **R** radiating

How bad is the pain at its LOWEST? (no pain) 0-1-2-3-4-5-6-7-8-9-10 (worst pain/discomfort ever)

How bad is the pain at its HIGHEST? (no pain) 0-1-2-3-4-5-6-7-8-9-10 (worst pain/discomfort ever)

How often is your pain at its lowest point? _____ How often is your pain at its highest point? _____

When & how did the pain/discomfort start? _____

How does it affect your life? _____

How low does your energy go at its LOWEST? (have to sleep) 0-1-2-3-4-5-6-7-8-9-10 (bounding energy)

How high does your energy go at its HIGHEST? (have to sleep) 0-1-2-3-4-5-6-7-8-9-10 (bounding energy)

How often is your energy at its lowest point? _____ How often is your energy at its highest point? _____

What are your goal(s) for your health at this time? Relief of present symptoms Develop optimum health

What does vibrant health mean to you? _____

Check off any of the following you are currently experiencing:

Endocrine

- Low thyroid (hypo-) High thyroid (hyper-) Diabetes Weight gain or weight loss

Eyes, Ears, Head, Neck

- Dry eyes Blurry vision Earaches Migraines/headaches
 Itchy eyes Poor night vision Decreased hearing Fainting
 Red, burning eyes Eye pain Ears ringing (tinnitus) Enlarged lymph glands
 Spots / floaters Dizziness Foggy unclear thinking Other: _____

Nose, Throat, Mouth

- Thirst for Warm or Cold Sinus congestion Allergies Swollen glands
 Difficulty swallowing Runny/post-nasal drip Tongue/mouth ulcers Itchy/sore throat
 Dry nose/mouth Nosebleeds Bitter taste in mouth Other: _____

Cardiovascular

- Rapid heartbeat Chest pain/tightness Insomnia (difficulty sleeping) High/low blood pressure
 Palpitations Swollen ankles Unpleasant dreams High cholesterol
 Irregular heartbeat Poor circulation Restlessness, anxiety Other: _____

Respiratory

- Cough Coughing up blood Frequently catch colds & flu's
 Coughing up phlegm Wheezing/Asthma Shortness of breath Other: _____

Genito-Urinary

- Painful/itchy genitals Frequent or urgent Blood in urine Bedwetting
 Genital lesions/discharge Difficult urination Unable to hold urine Wake up to urinate
 Painful/burning urination Profuse urination Scanty urination Chronic infections

Gastrointestinal

- Nausea, vomiting Fatigue after eating Diarrhea Itchy anus
 Belching Always hungry Blood and/or mucus in stools Burning anus
 Acid reflux/heartburn Bad breath Intestinal pain or cramping
 Gums bleeding/swollen Constipation Hemorrhoids
 Gas/Bloating Loose/soft stools Anal fissures Other: _____

Muscles & Joints

- Muscle spasms/twitches Joint pain/swelling Soreness, weakness, or pain in Back or Knees
 Body aches/stiffness Numbness/tingling Spinal curvature
 Weakness in muscles Heaviness in body Other: _____

Skin

- Hives Eczema Acne prone Bruise easily
 Rashes Psoriasis Dry skin Other: _____

General

- Cold or Hot body Spontaneous sweats Fatigue easily Anger easily
 Cold or Hot hands / feet Night sweats Poor memory Sadden easily
 Fever and/or chills Hair loss Infertility Anxiety/nervousness

FAMILY HISTORY

Circle any of the following conditions that have occurred in your family (parents, grandparents, siblings):

- | | | | | | |
|---------------|---------------------|------------------|----------------|--------------------|-------------|
| Alzheimer's | Arthritis | Asthma | Cancer | Diabetes | Eczema |
| Heart disease | High blood pressure | High cholesterol | Mental illness | Multiple sclerosis | Parkinson's |
| Stroke | Thyroid condition | | | | Stones |

Other: _____

Please describe any past surgery or reason for hospitalization: _____

Circle if you currently use, OR did use any of the following: Cigarettes / Alcohol / Recreational Drugs

List any *current* prescription drugs, over-the-counter drugs, herbal medicines and/or supplements you are taking:

List any allergies you may have (food, drug, herbal, environmental): _____

Are you a vegetarian? Yes No Do you have a pacemaker? Yes No
Have a serious heart or lung condition? Yes No Do you bleed easily? Yes No
Do you have epilepsy? Yes No Are you HIV positive? Yes No
Do you have any surgeries scheduled? Yes No Ever had infectious or serious diseases? Yes No

How would you describe your work?
 Physically demanding with heavy lifting, climbing, or repetitive arm/wrist/leg movements Mostly sitting
 Variety of sitting, standing and walking Boring Satisfying Highly rewarding

WOMEN'S HEALTH

Is there a chance you could be pregnant? Yes No
Have you ever used birth control? Yes No What type? _____ How long? _____
of pregnancies _____ # of live births _____ # of miscarriages, abortions or stillbirths (circle) _____

Age at your very first period (menarche)? _____ years old
Date of most recent period (onset)? _____
How long between your periods? (onset to onset): _____ Average # of days of flow: _____

Flow is : Heavy Light Average
Color is: pale red / pink bright-red dark-red purple brown black
Clots in menstrual blood? Yes No Spotting outside of your menstrual flow? Yes No
Circle any of the following pre-menstrual or menstrual symptoms you may have or used to have.

Breast tenderness	Irritable & moody	Acne breakouts	Headaches	Fatigue
Bloating / Cramps	Diarrhea	Constipation	Insomnia	Sweating

List any other menstrual symptoms you may have, or used to have: _____

Have you experienced menopause? Yes No When? _____

List your menopausal symptoms: _____

Are there any other concerns you feel are impacting your health? _____

MEN'S HEALTH

Do you have any of the following?
 Hernia Testicular mass or pain Discharge or sores Impotence
 Low sex drive Prostate condition Erectile Dysfunction

Are there any other concerns you feel are impacting your health? _____

Please share how you came to know about the TCM services of Dr. Mee Lain Ling, Dr. TCM:

Friend Family Member Colleague Family Physician Referral
 Other Referral Website/Internet Newspaper Other _____



CLIENT CONSENT FORM

This consent covers the following TCM treatment modalities:

- | | |
|---|-------------------|
| * Cupping Therapy (all types) | * Herbal Medicine |
| * Acupuncture | * Dietary Therapy |
| * Medical Massage (Tui Na, acupressure, electro-) | * Moxibustion |

I acknowledge that I have discussed, or have had the opportunity to discuss the nature and purpose of TCM treatment(s) in general, and my treatment(s) in particular, as well as the contents of this consent, with my Doctor of Traditional Chinese Medicine, Dr. Mee Lain Ling.

With regard to acupuncture and wet cupping, I have been advised that all needles are sterilized and disposed of after each treatment session.

I further understand and am informed that, as with all health care, the practices of Acupuncture, Cupping, Moxibustion and Medical Massage pose slight risks, which may include, but are not limited to: temporary bruising, soreness or sensitivity in the area(s) treated, swelling, blistering, bleeding, light-headedness, fainting, and nausea.

I also understand that adverse herb-drug reactions or interactions between prescribed Herbal Medicine or foods, with prescribed western medications, supplements or natural health products, though rare, may occasionally occur.

I have read the following and understand that:

- I am responsible for my own health.
- It is my responsibility to inform the Dr. TCM of any medical conditions or allergies that I am aware of and any medications, supplements, or herbs that I am currently taking.
- It is my responsibility to inform the Dr. TCM if I am pregnant, may be pregnant, or am breast feeding.
- While changes in habits are not a pre-requisite for treatment, failure to follow the recommended dietary and/or lifestyle programs could undermine expected results. I understand that it may take time to reach my health goals when using TCM. I accept that positive changes will occur more rapidly with increased compliance.
- It is my responsibility to clarify treatment questions with my Dr. TCM.
- I am free to discontinue treatment at any time.
- In the event I will be late, I will call to confirm availability. If I need to cancel or change my appointment time, I promise to respectfully give a minimum 24 hours notice, or be subject to the cancellation fee of \$60.
- I accept full responsibility for any fees incurred during care and treatment, and agree that payment is due when services are rendered.

I understand and am informed that the information received and collected from me for the purpose of providing me TCM treatment is strictly private and confidential. I understand my medical records and lab reports may be reviewed, and that all my records will be kept confidential and not released without my written consent.

I have read this statement and fully understand it.

I hereby consent to traditional Chinese medical diagnosis and treatment as described to me by Dr. Mee Lain Ling, Dr. TCM. I intend for this signed consent to apply to the entire course of treatment for my present condition and further conditions for which I seek TCM treatment from Dr. Mee Lain Ling, Dr. TCM.

_____ Client Signature <i>(legal guardian if client under 18 yrs)</i>	_____ Client Name (Printed)	_____ Date
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_____ Witness Signature	_____ Witness Name (Printed)	_____ Date
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