Doctor of Traditional Chinese Medicine

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** _____

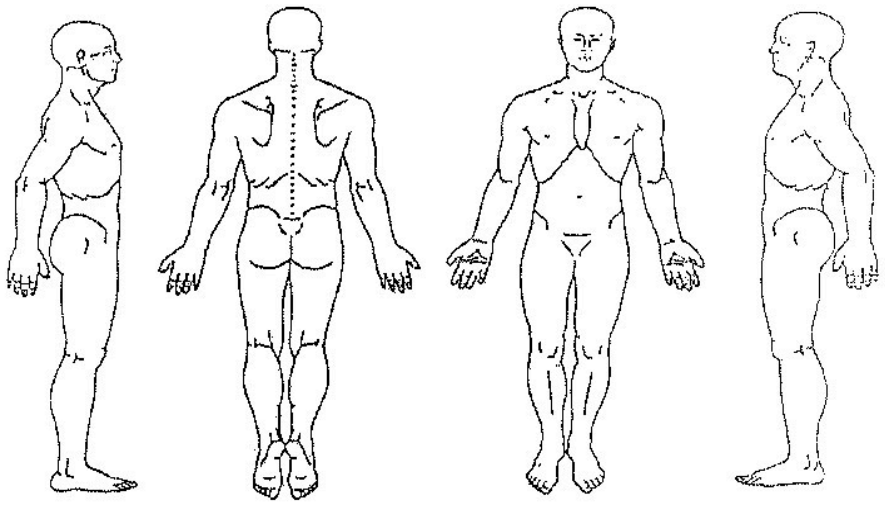
Email _____ Had acupuncture or Chinese medicine before? YES NO

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? O Relief of present symptoms O Develop optimum health
What does vibrant health mean to you? _____

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Check off any of the following you are currently experiencing:

Endocrine

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

Eyes, Ears, Head, Neck

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

Nose, Throat, Mouth

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

Cardiovascular

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

Respiratory

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

Genito-Urinary

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

Gastrointestinal

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

Muscles & Joints

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

Skin

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

General

O Cold or Hot body	O Spontaneous sweats	O Fatigue easily	O Anger easily
O Cold or Hot hands / feet	O Night sweats	O Poor memory	O Sadden easily
O Fever and/or chills	O Hair loss	O Infertility	O 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 Stones
Stroke	Thyroid condition				

Other: _____

Please describe any past surgery or reason for hospitalization: _____

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

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

WOMEN'S HEALTH
Is there a chance you could be pregnant? O Yes O No
Have you ever used birth control? O Yes O 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 : O Heavy O Light O Average
Color is: O pale red / pink O bright-red O dark-red O purple O brown O black
Clots in menstrual blood? O Yes O No Spotting outside of your menstrual flow? O Yes O 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?

O Hernia	O Testicular mass or pain	O Discharge or sores	O Impotence
O Low sex drive	O Prostate condition	O Erectile Dysfunction	

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

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

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

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CLIENT CONSENT FORM

This consent covers the following TCM treatment modalities:

* Cupping Therapy (all types)
* Acupuncture
* Medical Massage (Tui Na, acupressure, electro-)
* Herbal Medicine
* Dietary Therapy
* 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 *(legal guardian if client under 18 yrs)*	Client Name (Printed)	Date
_____	_____	_____
Witness Signature	Witness Name (Printed)	Date

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