Acupuncture & Chinese Medicine – Patient Consultation Form
Confidential

Today's Date: _____ / ____ / ____
month day year

NAME: _____ / _____ / _____
last name first name middle name

ADDRESS: _____ / _____ / _____
apt #, street #, street name city postal code

BIRTH DATE: _____ / ____ / _____ AGE: ___ OCCUPATION:_____
month day year

PHONE: home: _____ work: _____ cell: _____

EMAIL: _____ Would you like to receive email correspondence from Dr. Maryam? ☐ Yes ☐ No

FAMILY PHYSICIAN (if any): _____ Location: _____
Phone: _____
Do you have any objections to your family physician being contacted about the progress of your condition? ☐ Yes ☐ No

How did you hear about this clinic? _____

Have you ever been treated with Chinese Medicine/Acupuncture?
☐ Yes: when? _____ ☐ No

Reason for today's visit (chief complaint(s)):
_____
_____
_____
Your physician's diagnosis (if any): _____

Please list any prescription medications and/or over the counter drugs you are currently taking:
_____
_____

Please list any allergies you may have (food, drugs, herbal, environmental) if any:
_____
_____

Dr. Maryam

Are you a vegetarian? ☐ Yes ☐ No
Are you pregnant or is there a chance you may be pregnant? ☐ Yes ☐ No
Do you wear a pacemaker? ☐ Yes ☐ No
Have a serious heart or lung condition? ☐ Yes ☐ No
Are you a haemophiliac? ☐ Yes ☐ No
Do you have epilepsy? ☐ Yes ☐ No
Are you HIV positive? ☐ Yes ☐ No
Do you have any surgeries scheduled? ☐ Yes ☐ No
Are you taking anticoagulant medications? ☐ Yes ☐ No

Have you ever been hospitalized and/or treated for any infectious or serious diseases and what kind of diseases?_____

Please list any herbal medicines and/or supplements you are taking:

_____

_____

Please circle if you use any of the following: Cigarettes / Alcohol / Drugs

What goal(s) do you have for your health care at this time?
□ Relief of present symptoms □ Development of optimum health potential □ Long term health care

(Please complete the following section - For Female Patients only)
Gynecological History

Age of your very first period? _____ years old

Date of last period (when menstruation arrived)? _____
Cycle length (ie..28 days): _____ Is your cycle regular? □ Yes □ No
Describe your flow: □ Heavy □ Light □ Average
Color of your flow: □ pink □ bright-red □ dark-red □ purple □ brown □ black
Do you have large clots in menstrual blood? □ Yes □ No
Do you have cramps during menstruation? □ Yes □ No
Do you have spotting outside of your menstrual flow? □ Yes □ No

Do you have any of the following Pre-menstrual symptoms?
□ Breast tenderness □ Headaches
□ Irritability & mood swings □ Bloating
□ Acne breakouts □ Fatigue
Please list any other menstrual symptoms you may have:_____

_____

Dr. Maryam

Please check off any of the following symptoms you are experiencing:

Eyes, Ears, Head, Neck
- ☐ Dizziness
- ☐ Fainting
- ☐ Enlarged lymph glands
- ☐ Migraines/headaches
- ☐ Ringing in the ears (tinnitus)
- ☐ Decreased hearing
- ☐ Earaches
- ☐ Blurry vision
- ☐ Spots/floaters
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Poor night vision
- ☐ Red, burning, itchy eyes
- ☐ Other: _____

Cardiovascular
- ☐ Rapid heartbeat
- ☐ Chest pain/tightness
- ☐ Irregular heartbeat
- ☐ Swollen ankles
- ☐ Poor circulation
- ☐ Other: _____

Respiratory
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Shortness of breath
- ☐ Wheezing/Asthma
- ☐ Frequent colds & flu's
- ☐ Other: _____

Nose, Throat, Mouth
- ☐ Bleeding gums
- ☐ Sinus infection
- ☐ Hay fever allergies
- ☐ Swollen glands
- ☐ Difficulty swallowing
- ☐ Bitter taste in mouth
- ☐ Tongue/mouth ulcers
- ☐ Nose bleeds
- ☐ Dry mouth/thirst
- ☐ Other: _____

Muscles & Joints
- ☐ Joint pain
- ☐ Body aches/stiffness
- ☐ Weakness in muscles
- ☐ Spinal curvature
- ☐ Numbness/tingling
- ☐ Heaviness in body
- ☐ Backache or knee pain

Other: _____

Genito-Urinary
- ☐ Pain/itching of genitalia
- ☐ Genital lesions/discharge
- ☐ Painful urination
- ☐ Frequent or urgent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Wake up to urinate
- ☐ Bedwetting
- ☐ Decreased sex drive
- ☐ Other: _____

Gastrointestinal
- ☐ Nausea and/or vomiting
- ☐ Acid reflux/heartburn
- ☐ Gas
- ☐ Bloating
- ☐ Bad breath
- ☐ Loose/soft stools
- ☐ Constipation
- ☐ Blood and/or mucus in stools
- ☐ Intestinal pain or cramping
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Anal fissures
- ☐ Hemorrhoids
- ☐ Other: _____

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

General
- ☐ Cold hands & feet
- ☐ Fever and/or chills
- ☐ Night sweats
- ☐ Spontaneous sweats
- ☐ Recent changes in weight
- ☐ Fatigue

Fees (do not include GST)

Treatment	Cost Per Session
Initial consultation plus Acupuncture	$130.00
Acupuncture	$85.00 (45 min)
Follow-up office visit (no acupuncture)	$30.00
Herbal medicine	$30.00 per 80 grams
Initial Cosmetic Acupuncture Consultation	No Charge (20 min)
Cosmetic Acupuncture (Facial Rejuvenation)	$115.00

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Patient Consent Form and Appointment Policy

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are any particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients.
- Minor bleeding or bruising can occur from acupuncture.
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
- Fainting can occur in certain patients, but this is very rare.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.
I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

Privacy Policy

The information received and collected about our clients/patients from their visit to The Acupuncture & Chinese Medicine Clinic of Vancouver is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by The Acupuncture & Chinese Medicine Clinic of Vancouver, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of The Acupuncture & Chinese Medicine Clinic of Vancouver (also, The Acupuncture & Chinese Medicine Clinic of Vancouver will not give, share, sell or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient.

Appointment Policy

Many of our clients are pleased to find out that we are usually on time. This is because **your treatment has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time.
Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability.
A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid a cancellation fee of $30-$60. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

By voluntarily signing below, I show that I have read this consent to treatment, and have been told about the risks and benefits of treatments provided by this clinic. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.
I have read this statement and fully understand it.

Print Name_____

Signature _____ **Date** _____

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