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**Informed Consent for Traditional Chinese Medicine Treatment**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I hereby request and consent to receive Traditional Chinese Medicine (mentioned as TCM hereinafter) treatments including acupuncture, herbal medicine, Tuina massage, and other related modalities within the scope of practice of TCM practitioners and Acupuncturists performed at The Lakeside Clinic Center for Integrated Medicine.I understand that, as with all health care, while rare, there may be some risks to treatment, including;* With acupuncture:
	+ Occasional bruising, post-needling sensation, fainting, miner bleeding, blistering, nausea, infection and shock.
	+ Possible reasons for these symptoms are nervousness, hunger, extreme tiredness, muscle tension, or moving of the body after needling
* With herbal medicine:
	+ Risk of reactions to treatment including nausea, vomiting, dizziness, headaches, malaise or general worsening of symptoms
	+ Unknown interactions between western medications and Chinese herbal medicines
* Other modalities:
	+ Risks relevant to treatment such as bruising or bleeding

I also understand that transitions in healing (known as healing crisis) may also produce temporary periods of discomforts including emotional upset, fatigue, malaise, headaches, dizziness, rashes or breakouts, nausea, vomiting or general worsening of symptoms.TCM treatments in general are safe and effective for the prevention and treatment of a wide range of health conditions and for the promotion of general well-being. However, it is not intended to replace tests or treatments recommended by your physicians. I acknowledge that the above treatments and all their ramifications have been fully explained to me and I do not expect the practitioners to be able to anticipate and explain all possible risks and complications. I also absolve the clinic and its practitioners if I experience from any unexpected results of the treatment. I further agree to not commence lawsuit of any kind against all parties mentioned.

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|  |  |  |  |  |
| Name of the Patient/Guardian |  | Signature |  | Date: YY/MM/DD |

**Cancellation Policy**The clinic requires 24 hours notice when cancelling an appointment. Please be aware that a fee of $50 will be applied for late cancellation or missed appointment.**Cancellation Agreement**I understand that I am responsible for payment in full for appointments that are missed without 24 hours notice (1 business day).**I have read and agree to the above policy.**

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|  |  |  |  |  |
| Name of the Patient/Guardian |  | Signature |  | Date: YY/MM/DD |

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**Application for Treatment**

**Personal Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  |  |  | Date |  |
|  | First | Middle | Last | Gender | [ ] Male [ ] Female |
| Address |  | Date Of Birth |  |
| City |  | Postal Code |  |
| Phone | Home |  | Cell |  | Work |  |
| Email |  | Emergency Contact |  |
| Benefits Info | Company: Plan #: ID #:  |
| Chief Complaint | The reason why you seek for Traditional Chinese Medicine. |
| Current Medication | Please write here all medications that you are currently taking. Or let us have a photocopy of the list of medications you are currently taking. |
| Physician |  | Contact Number |  |

**Purpose of Visit**

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| --- |
| [ ] Consultation only [ ] Consultation with Treatment |
| Treatment Modalities | [ ]  Acupuncture [ ]  Herbal Medicine [ ]  Tuina Massage [ ]  Other |
| Other | Please describe here other modalities such as moxibustion, cupping, Guasha, etc. |

**Past Traditional Chinese Medicine History**

Have you ever been treated with Traditional Chinese Medicine? [ ]  Yes [ ]  No

If yes, please check any treatments you have received.

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| [ ]  Acupuncture [ ]  Herbal Medicine [ ]  Tuina Massage [ ]  Moxibustion [ ]  Cupping [ ]  Other |

**Medical History**

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| --- | --- |
| **Your Past Medical History:** | **Family Medical History:** |
| [ ] AIDS [ ] HIV [ ] HVB (Hepatitis B) [ ] Cancer [ ] Diabetes [ ] High Blood Pressure [ ] Heart Disease, Stroke[ ] Allergies [ ] Alcoholic[ ] Arthritis  | [ ] Seizures[ ] Thyroid Disease[ ] Surgeries[ ] Venereal Disease[ ] Significant Trauma (auto accident, falls etc.)[ ] Childhood Illness[ ] None[ ] Other: | [ ] Cancer (Mother/Father/Other)[ ] Diabetes (Mother/Father/Other)[ ] High Blood Pressure (Mother/Father/Other)[ ] Heart Disease, Stroke (Mother/Father/Other)[ ] Allergies (Mother/Father/Other)[ ] Arthritis (Mother/Father/Other)[ ] Seizures (Mother/Father/Other)[ ] None[ ] Other: |
| Additional description of the above illness or allergies (Please write below) |
|  |

**General Health Information**

To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly. Your answers will be kept totally confidential.

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| --- |
| **General information on your health condition** |
| Chills/Fever | [ ] general chills ([ ] mild [ ] severe) [ ]  aversion to cold [ ] cold limbs [ ] cold lower back [ ] cold abdomen [ ] tidal fever [ ] night fever [ ] afternoon fever [ ] mild fever [ ] high fever [ ] tidal fever [ ] hot flashes[ ] aversion to heat [ ] aversion to wind [ ] heat in the palms, soles and chest [ ] alternating chills and fever [ ] easily catch cold [ ] no chills or fever |
| Sweating | [ ] no sweating [ ] profuse sweating [ ] night sweating [ ] spontaneous sweating [ ] exhaustion sweating[ ] sweating on the palms, feet and chest [ ] normal  |
| Sleep | [ ] normal [ ] easily fall asleep [ ] insomnia [ ] easy to wake up and difficult to fall asleep again [ ] easy to wake up but easy to fall asleep again [ ] shallow sleep with easily awakened [ ] difficult to fall asleep when alone due to fear [ ] dream disturbed sleep [ ] excessive dreams [ ] sleep walking [ ] sleep talking [ ] nightmares [ ] seeing ghost [ ] wake up to urinate [ ] heavy feeling upon waking [ ] somnolence (sleepiness during the day) [ ] other:  |
| Sleeping Hours: |
| \_\_\_\_ / day |
| Head | [ ] vertigo [ ] dizziness [ ] edema or swelling [ ] poor memory [ ] heaviness [ ] fainting [ ] normal |
| Headache |  Location | [ ] frontal [ ] occipital [ ] vertex [ ] both sides [ ] sinusitis [ ] no headache |
| Quality | [ ] dull [ ] sharp [ ] moving [ ] stabbing [ ] fixed [ ] burning [ ] oppressing [ ] heavy |
| Eyes | [ ] red eyes [ ] dry eyes [ ] bulging eyes [ ] blurred vision [ ] short-sightedness [ ] night blindness [ ] floaters [ ] tearing [ ] photophobia [ ] pain [ ] itching on eyelids [ ] swelling [ ] normal |
| Ears | [ ] ringing in the ears [ ] tinnitus [ ] deafness [ ] diminished hearing [ ] normal |
| Nose | [ ] nasal discharge ([ ] clear white [ ] yellow sticky) [ ] nasal congestion [ ] rhinitis [ ] flaring sensation [ ] sneezing [ ] normal |
| Mouth/Lips | [ ] dry mouth [ ] dry lips [ ] ulcers [ ] normal |
| Throat | [ ] dry throat [ ] sore throat [ ] difficult to swallow [ ] frequent clearing [ ] feel something in the throat [ ] normal |
| Thirst | [ ] no thirst [ ] thirst with desire to drink ([ ] warm drink [ ] cold drink) [ ]  thirst without desire to drink |
| Appetite | [ ] poor [ ] excessive [ ] reduced recently [ ] increased recently [ ] no hunger [ ] hunger without desire to eat [ ] hunger even after overeating [ ] normal |
| Diet | [ ] irregular [ ] regular [ ] vegetarian | Crave for: [ ] spicy [ ] sweet [ ] greasy [ ] salty [ ] raw [ ] none |
| Digestion | [ ] nausea [ ] vomiting [ ] hiccup [ ] belching [ ] vomiting after eating [ ] acid regurgitation [ ] gas [ ] normal[ ] other:  |
| Taste  | Taste in the mouth: [ ] none [ ] bitter [ ] sweet [ ] sour [ ] salty [ ] pungent [ ] sticky sensation [ ] lack of taste |
| Chest | [ ] pain [ ] oppression [ ] palpitations [ ] fullness [ ] shortness of breath [ ] wheezing [ ] sighing[ ] cough with([ ] no sputum [ ]  sputum difficult to expectorate [ ]  sputum easy to expectorate [ ]  blood-streaked sputum [ ]  chest pain radiating to left shoulder, back and arm [ ] other:  |
| Abdomen | [ ] pain worse on pressure or warmth [ ] pain alleviated by pressure or warmth [ ] fullness [ ] distention[ ] pain, distention or fullness on the lateral costal region (rib-side or below rib-side) [ ] borborygmus[ ] gas with flatus (farting)  |
| Back | [ ] upper back pain [ ] lower back pain [ ] soreness [ ] coldness [ ] other: |
| Limbs | [ ] coldness [ ] numbness [ ] tingling [ ] spasm [ ] pain [ ] edema [ ] joint pain (see below) [ ] tremor |
| Joint pain | [ ] knee joint [ ] elbow joint [ ] moving pain [ ] fixed pain with heavy sensation [ ] hot, burning pain[ ] pain alleviated by warmth [ ] due to injury [ ] other:  |
| Skin | [ ] itchy [ ] dry [ ] moist [ ] edema [ ] rashes [ ] carbuncles [ ] allergic [ ] brittle nails [ ] other:  |
| **Urination and Bowel Movements** |
| Urination | Quality  | [ ] frequent urination [ ] hesitant urination [ ] difficult to urinate [ ] dribbling [ ] incontinence [ ] urgent urination [ ] burning sensation on urination [ ] painful urination [ ] enuresis[ ] bloody urination [ ] stone [ ] urinary blockage [ ] normal |
| Amount | [ ] scanty [ ] copious [ ] normal | Frequency | \_\_\_\_\_\_\_ times / day |
| Color | [ ] clear [ ] dark yellow [ ] milky [ ] turbid [ ] normal yellow |
| Defecation&Bowel Movement | General | [ ] constipation [ ] diarrhea ([ ] watery [ ] foul-smelling [ ] dawn) [ ] dysentery [ ] alternating constipation and diarrhea [ ] normal |
| Quality | [ ] dry stools [ ] hard stools [ ] loose stools [ ] undigested food in the stools [ ]  stools with mucus [ ] stools with pus [ ] bloody stools [ ] foul-smelling [ ] normal |
| Shape | [ ] well formed [ ] shapeless [ ] thin stools [ ] unsmooth [ ] pencil-like stools[ ] hard initial stools followed by loose stools |
| Condition | [ ] urgent defecation [ ] tenesmus [ ] fecal incontinence [ ] difficult but successfully pass out [ ] try to pass out with no result [ ] burning sensation around the anus |
| Color | [ ] normal yellow [ ] dark yellow [ ] black tar-like [ ] grayish white [ ] other:  |
| Frequency | \_\_\_\_\_ times / day or \_\_\_\_\_ times / week |
| **Emotions and Stress** |
| Fatigue | [ ] fatigued [ ] sleepiness [ ] heavy head and limbs [ ] lassitude [ ] fatigue with desire to lie down |
| Emotion | [ ] normal [ ] irritable [ ] anxious [ ] depressed [ ] fearful [ ] restless [ ] prone to anger [ ] mood swinging[ ] manic tendencies [ ] easy to cry [ ] over-thinking [ ] nervous |
| Stress | Causes |  | Level | /10 |
| Energy | Feeling |  | Level | /10 |
| **Female Condition** |
| Menstruation | Menarche Age |  | Date of last period |  | Duration (flow) |  |
| Intervals |  | Amount |  | Clots |  |
| Color |  | Contraception | [ ] Y [ ] N | Menopause | [ ] Y [ ] N |
| PMS |  | Other discomfort |  |
| Pregnancy | [ ] Yes [ ] No | Child Birth |  |
| Leucorrhea | Color |  | Smell |  | Amount |  |
| **Male Condition** |
| [ ] normal [ ] seminal emission [ ] impotence [ ] unable to erect [ ] premature ejaculation [ ] nocturnal emission [ ] nocturnal emission with dream [ ] no sexual desire [ ] excessive sexual desire [ ] prostatic hypertrophy [ ] other:  |
| **Life Style** |
| [ ] on diet [ ] exercise ( times/week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ] smoking ( cigarettes/day) [ ] drug [ ] meditation [ ] yoga [ ] alcoholic drinking ([ ] slight [ ] heavy) Frequency of drinking ( times/week) [ ] other: |
| **Other helpful information for your treatment** |
|  |

Thank you for your cooperation!