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**Informed Consent for Traditional Chinese Medicine Treatment**

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

**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**

|  |  |
| --- | --- |
| 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.

|  |
| --- |
| Acupuncture  Herbal Medicine  Tuina Massage  Moxibustion  Cupping  Other |

**Medical History**

|  |  |  |
| --- | --- | --- |
| **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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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!