Patient Information Form

Patient's Name: ____ Date: _______________

Address: ____ Phone (Work): _______________

City ____________________Postal Code ______ (Home): _______________ (Cell): _______________

Age: ____ Sex: M/F Weight: _______ Height: ________ Hand: R/L Birth date: _________
____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

Occupation: ___________________________ Employer: ____________________________
Emergency Contact: ___________________ Phone: _______________
Who is your Family Physician? ______________________________ Phone: ____________

How were you referred to Dr. Desmond?(check choices)___Family Doctor, ___friend, ___website, ____newspaper, ____other:
Please explain:__________________________________
Are you being treated for any medical condition at the present or have you been treated in the past year? Yes/No (circle)
____

What is your primary reason for seeking Health Care?
____

Describe the symptoms of your present condition:
____

Date the condition first began: ____

Did anything cause this condition? Yes / No (circle) Please explain: ___________________
____

Do you have any other areas of complaint? Yes / No (circle)
If so, please explain: ____

Have you had any treatment for this problem? Yes / No
What type of treatment? ____
Did it help? Yes / No (circle)

Please list any tests that have been performed, and where they were performed:
X-Ray: ____
MRI: ____
CT Scan: ____
Bone Scan: ____
Lab Work (Blood, Urinalysis, Etc.): _________________________________
Other: ____

List any fractures/ broken bones and dates: ____
List all surgeries/hospitalizations: Date:
_____________________________ ________________________
_____________________________ ________________________
Do you have any conflict or stress at home and/or work? Yes / No (circle) If so, please explain:
____

Do you smoke? Yes / No (circle) Do you drink alcohol? Yes / No (circle)

If so, do you drink: ______Occasionally ______ Moderately ______ More than 10 Drinks/Week
Have you ever had a problem with drugs or alcohol abuse? Yes / No (circle)

Do you get regular exercise? ______ None ______Weightlifting ______Walking ______Athletics ______Other Aerobics ______Stretching
______Running Other: ____________________________________

Do you have any **allergies** Yes/No (circle)
If so, please list them: ____

Have you ever contracted any **chronic infection**? (eg. Previous surgery or hospitalization?) Yes/No (circle)
If so, please list ____

Have you ever had a peculiar or adverse reaction to any medicines? Yes/No (circle)
If so, please describe it.____

Do you have any heart or blood pressure problems? Yes/No (circle) _________________________

Have you ever been told you have heart murmur or mitral valve prolapse? Yes/No (circle)
Have you ever had rheumatic fever? Yes/No (circle)
Have you ever had Hepatitis? Yes/No (circle), Jaundice? Yes/No (circle) , Liver Disease? Yes/No (circle), Or have you ever had contact with anyone with these conditions? Yes/No (circle)

Family History (check all that apply)

________ Heart Disease ________Rheumatologic Disease ________Nerve Disease________ Bone Disease ________Multiple Sclerosis
________ Migraine Headaches________ Tuberculosis ________Cancer ________ Respiratory Disease Other____________________

Have you ever been told not to give blood? Yes/No (circle) Have you ever had a blood transfusion? Yes/No (circle)
Have you ever had any conditions which could affect your immune system? Leukemia? Yes/No (circle) AIDS or HIV? Yes/No (circle)
Do you bruise easily or bleed for a prolonged period of time after a cut? Yes/No (circle)

Have you ever been diagnosed with any of the following conditions? (check all that apply)
____Aids/HIV, ____Asthma/Respiratory, ____Cancer, ____Diabetes, ____Kidney Disease, ___ Hepatitis, ___ Heart Attack/Year ____
____Stroke/Year ____ , ____ Heart Arrhythmia, ____ Heart Disease, ____ Blood Clots, ____ Bleeding Disorders, ____Hemophilia,
____Blood Pressure: High / Low (circle), ____ Hypoglycemia, ____Radiation/Chemotherapy, ____Migraines, ____Chronic Bronchitis
____Digestive Disorder, _____ Stomach Ulcers, ____Thyroid Trouble, ____Blindness, ____Depression/When _________,
____Emphysema, ____Epilepsy, ____Diabetes, ____Arthritis, ___Artificial Joint Replacement, ____Menopause/Menstrual,
____ Insomnia, ____Fatigue Disorder, ___Dermatological Disorder, ____Other Health Conditions
Please specify: ____
____

Gynecological (Women Only)

Could you be pregnant? _____Yes ______No ______ Due Date: ____________________
Any other Gynecological condition, please specify:
____

Is there anything that has been left out of your history that your feel is important to your healthcare? If so, please specify below:
____

Are you taking any medications or non-prescription drugs of any kind? Yes/No (circle)
Please list all meds & dosages: ____
____
____

Vital Signs: Blood Pressure: Systolic_____________Dystolic:______________ Pulse:___________________

WHAT YOU CAN EXPECT ON YOUR FIRST VISIT

1. I will greet you, perform an examination of your condition.

2. After determining the problem, I may perform treatment (TCM, Acupuncture, Laser Therapy, Injection Therapy* Herbology, Essential Oils Aroma Therapy, Physical Therapy, Energy Therapy, Lifestyle Suggestions, Tui Na body alignment) depending upon the examination findings.

Note* Injections contain only preservation-free naturally compounded injectable ingredients which may include one or several of the following ingredients: Glucosamine Sulfate, Cyanocobalamin B12, Procaine or Dextrose and other injectable Homeopathic Medicines.

3. I may make referral suggestions relating to other specialists, depending on the results of your visit.

4. We will then schedule your upcoming appointments based on medical necessity.

*****Please feel free to ask questions about your condition.**

Do you have any questions for the Doctor?________________ Dr. Sterling Desmond, D. TCM

1. ____
2. ____
3. ____

Dr. Desmond is licensed by the Province of British Columbia as a Doctor of Traditional Chinese Medicine. He is also a member of TCMABC (Traditional Chinese Medicine Association of BC), QATCMA (Qualified Acupuncturists and TCM Practitioners Association), and BCAPA (BC Association of Practicing Aromatherapists), a Registered Aroma therapist, Registered Acupuncturist, and Counselor. He has a B.A., B. Com (Hons.), R.A.C., Doctor of Traditional Chinese Medicine.

I attest that all the answers on this history form are honest and answered to the best of my knowledge.

Patient Name: (please print)____

Patients Signature________________________________ Date __________________

I apologize for the lengthiness of this history form. However, I need as much information as possible to get to the root of your problem, and assist you in resolving it. Thank You.

INFORMED CONSENT FOR TCM TREATMENT AND CARE:*

*I apologize for the additional form for patient consent, however, as of September 1, 2011, this form fulfills the basic legal requirements for securing a valid consent or refusal for a proposed course of health care treatment for an adult in British Columbia.

I hereby request and consent to the performance of Acupuncture and related procedures associated with Traditional Chinese Medicine (TCM), by CTCMA registrant Dr. Sterling Desmond and/or any other qualified TCM practitioner/CTCMA registrant working in this clinic authorized by Dr. Sterling Desmond.

I understand that the methods of treatment may include but are not limited to Acupuncture, Electrical stimulation, Laser Therapy, Tui-Na body alignment, Energy therapy, Chinese herbology, Homeopathic medicines, Essential oils Aromatherapy, Injection Therapy*, Lifestyle counseling, and Nutritional counseling. Treatment may or may not include: moxibustion, cupping, gua sha according to CTCMA paradigms for Traditional Chinese Medicine. Note* Injections contain only preservation-free naturally compounded injectable ingredients which may include one or several of the following ingredients: Glucosamine Sulfate, Cyanocobalamin B12, Procaine or Dextrose and other injectable Homeopathic Medicines.

If I have further questions or concerns I will take the opportunity to discuss them with the doctor of TCM named above, the nature and purpose of TCM treatments and other procedures. I understand that results are not guaranteed. Traditional Chinese Medicine, while approved in other parts of the world, is still considered experimental in Canada.

I further understand and am informed that, as in all health care, in the practice of TCM there are some minor risks, and/or side effects, albeit rare, to treatment, including but not limited to: soreness, slight dizziness, bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. This office uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of moxibustion. There may be some bruising after cupping and gua sha that may last a few days. There have been very rare instances reported of spontaneous miscarriage and pneumothorax. I understand that while this document describes the major risks of treatment, other side effects and risks may occur, occasional tiredness, infection, injury to nerves, burns, scarring, and death from complications of the treatment, no benefit.

The herbs and nutritional supplements that are used are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy, contra-indicated with other medicines, and conditions. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will stop taking them and immediately inform the doctor.

I have also been informed that the risks of no TCM/Acupuncture treatment is zero. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels is in my best interest at the time, based upon the facts then known.

I understand the doctor and administrative staff may review my medical records and report, but all of my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read or have had read to me the above consent to treatment. I have been informed about the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

TO BE COMPLETED BY PATIENT :

Signature________________________ Name:________________________(please print) Date:_____________

Name & Signature of substitute decision maker (if required): ___________________ Witness:_____________

Revised October 3, 2011