

# Patient Information Form

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone (Cell): \_\_\_\_\_ Text: Y/N

City \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

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: \_\_\_\_\_  
\_\_\_\_\_

**Current Medications & Your History:**

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 or provide a separate information sheet: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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, Injection Therapy, Ozone Therapy, Tui Na (body alignment),Herbology, Essential Oils Aroma Therapy, Laser Therapy, Physical Therapy, Energy Therapy, Lifestyle Suggestions, depending upon the examination findings.
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. \_\_\_\_\_

Dr. Desmond is licensed by the Province of British Columbia as a Doctor of Traditional Chinese Medicine. A member of ATCMA (BC Association of Traditional Chinese Medicine & Acupuncture Practitioners), S.A.I.T. (Society for Acupoint Injection Therapy) and BCAPA (BC Association of Practicing Aromatherapists), a Registered Aromatherapist, Registered Acupuncturist, University B.A and Business Degrees, Certified in Homotoxicology, Prolotherapy, Biopuncture, Ozone therapies (FAAO-Fellow American Academy of Ozonotherapy), Doctor of Traditional Chinese Medicine, DrTCM

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, Injection Therapy, Ozone Therapies, Electrical stimulation, Tui-Na body alignment, Laser Therapy, Energy therapy, Chinese herbology, Homeopathic medicines, Essential oils Aromatherapy, Lifestyle counseling, and Nutritional counseling. Treatment may or may not include: moxibustion, cupping, gua sha according to CTCMA paradigms for Traditional Chinese Medicine.

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: \_\_\_\_\_