urban wellness
HOLISTIC HEALTHCARE

Patient Information | Health History | Consent and ROR

Traditional Chinese Medicine – Acupuncture – Herbal Medicine
489 College Street, Suite 301
Toronto, ON M6G 1A5
416 324 8888

Date: _____ Name: _____

Preferred pronoun: He/She Date of Birth: (DD/MM/YR) Age: ____

Address: _____ Postal code: _____

Phone (h): _____ (c): _____ E-mail: _____

Occupation: _____

Name of Doctor/Specialist: _____ Phone: _____

Name of other Health Practitioners: _____

Emergency contact: _____ Phone: _____

Referred by: _____

From time to time we send out an electronic newsletter with our upcoming workshops, events and talks, healthful ideas, recipes and inspirations. Are you interested in receiving this? _____

Please note you may unsubscribe to the newsletter at anytime.

What is the main condition for which you are seeking treatment?

_____

_____

What is the history of this condition (ie. when did it start, what makes it worse/better? what have you already tried for treatment?)

_____

_____

Previous Medical History:

List any previous **illnesses** including childhood illness or chronic viral infections, any **surgeries**, **traumas** or accidents, even if unrelated to your current condition.

_____

_____

_____

Are there any conditions that are significant in your **family's medical history**? (eg. heart disease, cancer, stroke, high blood pressure, kidney disease, diabetes, asthma, ulcers, mental/emotional disorders, etc)

_____

_____

Please list any allergies and the reaction you have:

_____

_____

Please list any medications or supplements you are currently taking:

_____

_____

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Dental History:

List any previous dental surgeries:

_____

Number of amalgam fillings, if any? _____

Lifestyle:

Diet – List what you might eat on a typical day:

_____

_____

How is your appetite? _____ How often do you have a bowel movement? _____

What medications or supplements are you currently taking and for what reason?

_____

_____

Do you drink coffee? _____ If so, how many cups per day?_____
Do you drink alcohol? _____ If so, how much and how often? _____
Do you smoke? _____ If so, how many cigarettes per day? _____
Do you use recreational drugs? _____ If so, how often? _____
How many cups of water do you drink in a day? _____

Exercise – What is your typical activity in a day?

_____

_____

Are you on a regular exercise program? (Type of activity and frequency)

_____

_____

Relaxation – What is your level of personal and occupation related stress?

_____

When you are under stress, what is your most common emotional response? (Please check all that apply)

□ sadness □ anger □ worry
□ depression □ fear □ anxiety

What do you do for relaxation? How often do you actively relax?

_____

_____

How many hours of sleep do you get each night? _____
Do you feel rested when you wake up? _____
Do you work at a computer? _____ Do you use a cellphone? _____

What are your expectations from our work together?

_____

_____

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*Mark **current** symptoms **"C"***

General
___ Fatigue
___ Insomnia
___ Disturbed sleep
___ Frequent dreams
___ Excessive sleep
___ Dislike cold
___ Dislike heat
___ Weight loss
___ Weight gain
___ Fever
___ Chills
___ Night sweats
___ Daytime sweating
___ Usually thirsty
___ Seldom thirsty
___ Edema or swelling
Other _____

Skin
___ Rashes
___ Hives
___ Dry skin
___ Acne
___ Bruise easily
___ Changes in moles
___ Unusual bleeding
Other _____

Head and Neck
___ Headaches
(location and type of pain)
___ Dizziness
___ Jaw pain
Other _____

Eyes and Ears
___ Failing vision
___ Blurred vision
___ Visual spots
___ Night blindness
___ Eye pain or redness
___ Ringing in the ears
___ Decreased hearing
___ Ear pain/discharge
Other _____

Nose, Throat and Mouth
___ Nosebleeds
___ Nasal discharge/ infection
___ Frequent sneezing
___ Sore throat
___ Hoarseness
___ Difficult swallowing
___ Tooth or gum pain
___ Bleeding gums
___ Mouth ulcers
Other _____

Muscles and Joints
___ Pain, weakness or numbness in:
___ Neck/shoulder/arm
___ Hips/leg/feet
___ Low back & knees
___ Muscle cramps
___ Body pain
___ Heavy limbs
___ Swollen joints
___ Hot joints

Nervous System
___ Fainting
___ Paralysis
___ Tremors
___ Poor balance
___ Seizures
Other _____

Heart, Lungs & Chest
___ Palpitations
___ Chest pain
___ Chest tightness
___ Rapid heart beat
___ Irregular heart beat
___ Swelling of ankles
___ Cough
___ Dry cough
___ Coughing phlegm
___ Coughing blood
___ Short of breath
___ Asthma/wheezing
___ Frequent colds
___ Pain in rib cage
Other _____

Mental/Emotional
___ Difficult concentrating
___ Poor memory
___ Worry
___ Anxiety
___ Depression

*Mark **past** symptoms **"P"***
___ Irritability
___ Frustration or anger
___ Fearfulness
___ Stress
Other _____

Digestive System
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Loose stools
___ Stomach pain
___ Abdominal pain
___ Poor appetite
___ Excessive hunger
___ Abdominal bloating
___ Belching
___ Indigestion
___ Acid reflux
___ Hemorrhoids
___ History of eating disorder

Urinary/Genital
___ Painful urination
___ Difficult urination
___ Frequent daytime
___ Nighttime urination
___ Incontinence
___ Cloudy urine
___ Genital pain or itch
___ Genital discharge
___ Low sex drive
___ Excessive sex drive
___ History of STD _____

Female
___ Irregular periods
___ Painful periods
___ Spotting
___ Passing clots
___ Scanty or no periods
___ Early periods
___ PMS
___ Menopausal symptom
___ Abnormal PAP smear
___ Vaginal discharge
___ Breast lump
___ Breast pain/discharge
Other _____

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The mission of this practice is to work in partnership with clients using acupuncture and lifestyle modification to remind the body of its natural healthy state.

As the client, I understand:

- Methods or treatments may include, but are not limited to, acupuncture, acupressure, electrical stimulation of needles, moxibustion, cupping, Tui Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling
- If the treatment seems contraindicated or inappropriate, the practitioner may not continue treatment or refer me to the appropriate modality. Conversely, I have the right to consent to or refuse any of the recommended treatments
- That although reasonable precautions will be taken, I am undergoing treatments at my own risk. Such risk may include unforeseen complications or bodily injury, no guarantee can be made of a successful result or cure; slight pain, light-headedness or nausea, soreness, bruising, bleeding or discoloration of the skin and in some cases my symptoms may temporarily worsen before they begin to improve
- Anything discussed in the clinic will be confidential, with the exception of information revealed about children being abused or intended damage to persons or property. The practitioner is legally responsible to report such information to the proper authorities
- As a diverse and integrative clinic, there may be situations where it is necessary to share my personal information with Urban Wellness practitioners to provide optimal care, interventions, and services to my treatment plan
- The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastrointestinal reactions to the herbs I will inform the acupuncturist *immediately*.
- I must inform my practitioner of any major past or current health issues, such as: a carrier of any infectious agents, pregnancy status, fit, faint or other odd detached sensations, a pacemaker or any other electrical implants, damaged heart valves or have any other particular risk of infection, a bleeding disorder; consumption of anti-coagulants (blood thinners) or any other medication
- The fees for my treatments are not covered under OHIP and must be covered in full by myself or through third party insurance:
    - Initial consultation and treatment—$160.00 (for adults) / $95.00 (for children under 16 years of age)
    - Follow-up treatment—$95.00 (for adults) / $45.00 (for children under 16 years of age)
    - Community Acupuncture – Initial Consultations and treatment - $15 + $30-$60 (sliding scale rates) / Follow-up treatment –$30-$60 (sliding scale rates)
    - Herbs and nutritional supplement fees are dependent on the treatment plan outlined by the practitioner and patient
- I will pay the full charge of any missed or forgotten appointments without 24-hour notice of cancellation (by 5:00 p.m. on business days and by 5:00 p.m. Friday for Monday appointments)

I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

Patient Signature: _____ Date: _____

Practitioner signature: _____ Date: _____

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I, _____, or my appointed representative _____
please print *please print*

☐ consent ☐ do not consent

for Urban Wellness and Fertility Toronto to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.
In terms of information, Urban Wellness Fertility Toronto may collect any other the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information
I understand that my personal and medical history is available to me for my review under most circumstances.
Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions:
_____

_____

Patient Signature: _____ Date: _____

Witnessed: _____ Date: _____