Dong Giao TRAN Lic.# 3431
Acupuncturist | Traditional Chinese Medicine Practitioner
353 Dominion Avenue, Ottawa, ON, K2A 2H1 | 613 371 5559 | acupuncture@giaotran.ca | www.giaotran.ca

Initial Health History Questionnaire (4 pages in total)

Visit date: d _____ m _____ y _____

First name: _____ Last name: _____ Age: ____

Date of Birth: d_____ m _____ y _____ Gender: _____ Occupation: _____

Home #: _____ Cell #: _____ Best way to contact you: Cell / Home

E-mail address*: _____

FOR PRIVACY, use private email address, the one that ONLY YOU have access to its content!

Address:_____ City: _____ Province: ___ Postal code: _____

Emergency Contact: Name: _____ Telephone: _____

Relationship: _____

Family Doctor: _____ Clinic Name or Address: _____

What is the objective of your visit? Please be descriptive (location, duration, triggers, causes…etc)

_____

_____

_____

Please write down one or two concerns or problems which you would <u>most</u> like us to help you with.

1._____

2._____

Are you using blood thinner? Y - N Do you have bleeding disorders? Y - N

Cancer type: _____ Stage: _____ Date of the diagnosis: _____

Did you have lymph-nodes removed? Approximate number and its locations _____

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PLEASE CIRCLE ANY RELEVANT DIAGNOSES OR HEALTH CONCERNS. PROVIDE MORE INFORMATION AT THE END OF THE FORM IF NEEDED	**Check if no concerns**
Infections: Chronic infections, Hepatitis, Tuberculosis	☐
Head and Neck: Headaches/migraines, Vision problems, Hearing problems, Tinnitus, Head Injury	☐
Cardiovascular: Heart attack, Stroke, High/low BP, High cholesterol, Pacemaker, Heart failure	☐
Respiratory: Asthma, Bronchitis, Chronic cough, Emphysema, Shortness of breath	☐
Endocrine: Diabetes, Type: _____ Do you use insulin?: _____, Thyroid (hyper/hypo)	☐
Digestion: Kidney stone (last occurrence: _____), Gas/bloating, Reflux, Constipation, Diarrhea	☐
Reproductive: Fertility issues, Pregnant, Planning to conceive, Menstrual issues, Menopausal	☐
Sexual health: Pain with sexual activity, erectile difficulties, loss of libido, vaginal dryness, itch…	☐
Urinary health: incontinence, urgency, incomplete/painful urination, urination hesitancy…	☐
Neurological/Musculoskeletal: Tingling/loss of sensation, MS, Rheumatoid/osteoarthritis, Epilepsy, Fibromyalgia, Tics, Spasm, Restless legs	☐
Mental Health: Anxiety, Depression, Trauma, Psychiatric diagnosis	☐
Other: Anemia, Hemophilia, Skin conditions, Organs issues, any other concerns not covered above: _____	☐

PLEASE PROVIDE A LIST OF YOUR PRESCRIPTION MEDICATIONS OR SUPPLEMENTS THAT YOU TAKE REGULARLY

_____ _____

_____ _____

_____ _____

HEALTH HISTORY INCLUDING PREVIOUS HOSPITALIZATION, SURGERY AND TREATMENTS (WITH APPROX. DATE)

_____ _____

_____ _____

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT FOR US TO KNOW?

_____

_____

Signature: _____ Completed by (check one): ☐ Patient ☐ Family caregiver

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CONSENT FORM FOR CARE

A number of gentle, non-invasive techniques may be used to develop an individualized treatment plan that addresses your unique needs. In your initial appointments, you can expect a physical examination and history taking.

Because some therapies must be used with caution with certain conditions (such as pregnancy and breast feeding, liver disease, heart disease, kidney disease, autoimmune disease) it is very important that you inform your clinician of any other disease(s) you are suffering from, as well as any medications, drugs, supplements and natural health products you are taking regularly. It is also important to inform your clinician of any allergies you may have at each visit.

There are potential health risks associated with the treatments offered at the clinic. These include but are not limited to:

1. Aggravation of pre-existing symptoms
2. Allergic reactions to supplements or herbs
3. Pain, bruising, injury, burns, blisters or fainting from acupuncture, scraping (or Guasha), cupping, acu-pressure or moxibustion (heat therapy)
4. Emotional or psychological distress

Please read the following:

1. In the event of a medical emergency during treatment, I authorize the practitioner to take such measures as they consider to be in my best interest.
2. I understand that results cannot be guaranteed.
3. I understand that direct emails or telephone calls to the practitioners are discouraged as medical issues cannot be safely or appropriately assessed without an office visit (if this is not possible, a telephone conversation may be scheduled with your practitioner that will be billed at the same rate as an office visit).
4. I understand the fees for this service apply to me, and that payment is due at each visit and that cancellations made under 24 hours will be billed.
5. I understand that there may be students and/or other practitioners attending and/or guiding the session for learning purposes.
6. I understand that information from my medical record may be analyzed and presented for research purposes but that my identity will be protected and kept confidential.
7. I understand that physical palpation is part of the assessment at each visit. If I feel uncomfortable at any point, I will let the clinician know promptly. Alternatively, I can request for a third person to be present in the treatment room such as a family member or a female assistant if available.

If you have any questions related to this please address them with your clinician directly.

Name (please print): _____ Date: d _____ m _____ y _____

Signature: _____

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PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I _____, or my substitute decision-maker _____
Print name Print name if applicable

Consent Do not consent

For Clinic to collect, use and disclose my personal health information for the purpose of providing traditional Chinese medicine or acupuncture to me and for the related purposes set out in the Clinic Written Privacy Statement.
The personal health information that may be collected, used or disclosed by the Clinic may include the following, among other things:

1. my birth date and contact information — my health history and family health history — my health status — my health number — the health care I receive (including identifying my health care provider(s))
2. the identification of my substitute decision-maker, if any
3. insurance or billing information relating to health care

I understand that there may be situations in which practitioners at the Clinic will have to collect, use or disclose personal health information without my consent, but that they will only do this if permitted by law.

How My Information Will Be Used

I understand that my personal health information may be collected, used or disclosed for the following reasons:

1. To provide me with traditional Chinese medicine or acupuncture services
2. To obtain payment for services provided
3. To assist insurance companies with insurance claims verification
4. To seek advice for potential treatment options
5. To provide or arrange health care in cases of emergencies
6. To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal health information is available to me for my review except in limited circumstances as permitted by law. I also understand that I can ask to have my personal health information corrected if I believe there is a mistake in the records, with some exceptions.

Acknowledgment

I allow the Clinic to collect, use and disclose my personal health information as outlined above.
I understand that I can access my personal health information with some limited exceptions.
I understand that I am not required to sign this form and that I can withdraw my consent at any time by contacting Dong-Giao TRAN, but it may directly affect the services I can receive. My personal health information may still be collected, used or disclosed if permitted by law.

Additional Comments or Restrictions: _____

Signature: _____ Date: d _____ m _____ y _____