Health History

Visit Date (D/M/Y): ____________________ **All information is kept private and confidential**

First name: ________________________________ Last name: _____________________________________ Sex: ________

Date of Birth (D/M/Y): ______________________ Occupation: ____

Home #: ___________________ Cell #: _______________________ Email: ______________________________________

Address: __________________________________ City: _____________ Province: ______ Postal code: ______________

Emergency Contact: ____________________________ Phone: ____________________ Relationship: ________________

Substitute Decision Maker and phone number (if applicable): ____

Family Doctor name: ____________________________ Contact information: _____________________________________

WHAT ARE THE GOALS OF YOUR VISIT?

WHAT ARE THE <u>CURRENT</u> PRESCRIPTION MEDICATIONS OR SUPPLEMENTS THAT YOU TAKE <u>REGULARLY</u> ? PLEASE SPECIFY THE <u>REASONS</u> FOR USE.

IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT FOR US TO KNOW? <u>USE EXTRA PAGE IF NEEDED</u>.

PLEASE CIRCLE ANY RELEVANT DIAGNOSES OR ONGOING HEALTH CONCERNS:

□ Are you often sensitive to cold? Y / N

□ Do you often have cold hands / feet? Y / N

□ **Digestion**: Loss of appetite, Bloat, Distention, Liquid stools, Slow / Hard stools, Hemorrhoid, Prolapse

□ **Urination**: Incomplete, Slow, Frequent, Blood, Bladder Prolapse, Other: ____________________

□ **Menstruation:** Heavy, Painful, Moods swings, Hot flashes, Night sweat, Fertility, Other: ____________

□ **HEART:** HIGH blood pressure, Pace-maker, History of stroke, Irregular heart beats or racing, Other: ________

□ **BLOOD**: Anemia, Low or High WBC / Neutrophils, Low or High platelets, Bleeding disorders, Other: ________

□ **Psychiatric diagnosis**: Anxiety, Depression, Panic attack, Other: ____________________

□ **Infectious disease**: ____________________

□ **Inflammation of organ(s)**: Liver, Kidneys, Spleen, Colons, Other: ____________________

□ Diabetes, type _____ Do you use insulin? Y / N

□ Skin conditions: ____________________

□ Sensitivities, allergies: ____________________

□ Do you have metallic implants: Y / N Please precise: ____________________

FOR PATIENTS LIVING WITH CANCER:

□ Cancer type: ______________ Stage _______ Diagnosed on (approximate date) ______________

□ Known location of the malignant tumour ____________________

□ Number of lymph-nodes removed: __________ Location(s): ____________________

□ On-going treatment(s): ______________ □ Past treatment(s) if applicable: ______________

ARE YOU PREGNANT OR EXPECTING? YES / NO

Signature: ____ X

Completed by: □ Patient or □ Substitute Decision Maker (SDM).

PATIENT INFORMED CONSENT TO TREATMENT

I consent to have MR. DONG GIAO TRAN, to perform the following treatment* on me: **Acupuncture**, **moxibustion** (heat therapy), **acupressure**, **herbal** treatment, with lifestyle, dietary, at-home exercises recommendations.

*If treatment includes sensitive areas, I, consent to have MR. DONG GIAO TRAN, provide assessment, and treatment of the areas indicated below: [**PLEASE CHECK** the appropriate box(es)]

☐ Abdomen to the pubic bone ☐ Upper and inner thighs ☐ Buttocks ☐ Chest wall muscles

I acknowledge that:

- There are potential health risks with the proposed treatment, including but not limited to:
    - aggravation of pre-existing symptoms; development of new symptoms or side-effects;
    - allergic reactions; pain, bruising, injuries, blisters or burns from acupuncture and heat therapies;
    - emotional or psychological distress;
- My practitioner cannot guarantee the results of the proposed treatment
- I have informed my practitioner about my relevant health history, including allergies, intolerances and sensitivities,
- I have discussed the content of this form with my practitioner
- **I have asked any questions I may have and received answers I understand.**

I understand that:

- my consent is voluntary, and I have the right to withdraw my consent to the treatment at any time.
- the fees charged for my treatment and herbal products are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. I acknowledge that my practitioner has explained the applicable fees to me, and the clinic policy, which can be found at www.TranAcupuncture.ca/information

Additional Comments or Restrictions: ______________________________ X

By signing this form, I give my informed consent for the treatment set out above.

Name and Signature, ______________________________ X

[☐ name of patient or ☐ the substitute decision-maker (SDM), please check]

By signing this form, I acknowledge that I have reviewed the form with the patient (or substitute decision-maker) and have answered the patient's (or substitute decision-maker's) questions.

Practitioner's Signature: DONG GIAO TRAN

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

How My Information Will Be Used

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

1. To assess your health concerns, provide health care and advise you of treatment options;
2. To seek advice for potential treatment options;
3. To establish and maintain contact with you;
4. To remind you of upcoming appointments;
5. To obtain payment for goods and services provided;
6. To assist insurance companies with insurance claims verification;
7. To provide or arrange health care in cases of emergencies;
8. To fulfill any obligations as mandated by law;
9. To be used for educational and research purposes (this includes case summaries, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary identifying information will be altered to protect your privacy in all the above instances.

Our privacy policy outlines what the Clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Our privacy protection protocols comply with Ontario's health privacy legislation (PHIPA);
- Storage, retention and destruction of your personal information complies with existing PHIPA legislation

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 <u>if permitted by law</u>.

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: ____ X

By inserting my name below I acknowledge that I have read and agreed to its terms.

Full Name of ☐ Patient / ☐ Substitute Decision Maker: ________________________________ X

Signature of ☐ Patient / ☐ Substitute Decision Maker: ________________________________ X