CHELSEA RANEY
Traditional Chinese Medicine

Young Health Management

HEALTH HISTORY

Please take the time to fill out this questionnaire carefully, and to the best of your ability. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

Name:_____ Sex: ☐ Male ☐ Female ☐ Other

Date of birth (yyyy/mm/dd)_____ Age: _____

Phone #:_____ Email:_____

Email will only be used by Young Health Management for appointment reminders.

If you would prefer text reminders please indicate your Cell Phone Service Provider:_____

☐ I would like to receive Practitioner Updates, Services Announcements and Newsletters from Chelsea Raney R.TCM.P

**The anti-spam legislation requires that we ask for your consent to send you emails.*

Address:_____

City/Province:_____ Postal code: _____

BC Care Card Number: _____

Extended Health Care Provider:_____ Policy Number: _____

Name of Plan Holder:_____ ID Number:_____

Family Doctor:_____ Doctors Clinic:_____

Emergency Contact Information Name: _____

Ph: _____ Relationship: _____

How did you hear about our clinic? _____

Appointment Policy

Welcome! We are delighted to have you as a client and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a moment to read our appointment policy:

*When you book an appointment, your treatment room has been reserved for you. A minimum of **24 hours** notice is required when cancelling or rescheduling an appointment in order to avoid a cancellation fee. This allows us time to schedule another patient that would benefit from treatment. Late or miss appointments will be charged to you at full cost.*

This appointment policy allows us to develop a mutual consideration and respect for our time and yours.
Please sign below to acknowledge you have read and understood the Appointment Policy.

Print name:_____Signature:_____Date:_____

Primary health complaint:

How long:

Other health complaints:

Are you currently receiving any therapy from another health care practitioner?

□ Medical Doctor □ Massage Therapist □ Chiropractor □ Physiotherapist □ Naturopath □ Dietitian □Other

Medications currently used:

Supplements and/or herbal medicines currently used:

Allergies/Reactions:

□ Medication □ Peanut □ Dust □ Pollen □ Dairy □ Gluten □ Wheat □ Chocolate □ Caffeine □ Other:

Habits:

□ Cigarettes □ Alcohol □ Caffeinated Beverages □ Sugar □ Exercise (approx. hrs/wk) _____ □ Other:

How much water do you drink each day?

Do you follow a special diet? Please describe:

Please give me a brief idea of your regular diet:

Breakfast:

Lunch:

Dinner:

Snacks:

What do you like to do for fun?

What Are Your Health Goals?

Past Medical History

□Mumps	□Herpes	□HIV+	□Hepatitis	□Blood Pressure (+/_)
□Stroke	□ Depression	□Gout	□Osteoporosis	□Shingles
□Fracture	□Arthritis	□Diabetes	□Tuberculosis	□Thyroid (+/_)
□Tumor	□Cancer	□Measles	□High Cholesterol	□Ulcer
□Asthma	□Other:			

Systems Review : Please check all that apply (if you are unsure make a note and we can discuss it)

Sleep

Sleep quality is good		Difficulty falling asleep		Easily fall asleep	
Sleep needs improvement		Frequent dreams		Wake up at night	
Sleep quality is very poor		Nightmares		Night sweats	
Light sleeper		Wake feeling tired		Fatigue	
Deep sleeper		Wake feeling rested		Snore	

Head, Eyes, Ears, Nose &Throat

Dizziness/Vertigo		Peculiar tastes/smells		Poor vision	
Difficulty swallowing		Photosensitivity		Night Blindness	
Headaches/Migraines		Eye pain		Color Blindness	
Cataracts		Blurred vision		Earaches	
Ringing in ears		Poor hearing		Spots in front of eyes	
Recurrent sore throats/colds		Nose bleeds		Sinus problems	
Grinding teeth		Facial pain		Sores on lips/tongue	
Dental problems		Jaw clicks/locks		Swollen glands	

Respiratory Function

Persistent cough		Shortness of breath		Nasal dryness	
Sneezing		Chronic allergies		Nosebleeds	
Post nasal drip		Sinus congestion		Wheezing	
Sore throat		Difficulty taking a full breath		Sleep apnea	

If you are a smoker, # of cigarettes per day _____ How long have you been smoking_____

If you are a smoker, do you want to quit? □Yes □No [Level of determination to quit- 1 2 3 4 5 6 7 8 9 10]

Cardiovascular

Chest pain or pressure		Palpitations at rest		Fainting	
Irregular heart beat		Swelling of hands/feet		Blood clots	
Bleed/Bruise easily		Phlebitis		Shortness of breath	
Varicose/spider veins		Pressure in chest		High blood pressure	
Low blood pressure		Rib side pain			

Digestive Function

Abdominal bloating		Belching		Gas	
Fatigue after eating		Food cravings		Indigestion	
Stomach pain		Acid reflux		Nausea	
Bad breath		Bleeding gums		Hiccupping	
Vomiting		Mouth ulcer		Ravenous appetite	
Strong thirst		Bloating		Poor Appetite	
Weight loss/gain					

Bowel Function

Diarrhea		Constipation		Blood in stool	
Mucous in stool		Less than 1 BM/day		Hard stool	
Loose stool		Rectal Pain		Hemorrhoids	
Gurgling intestines		IBS/Crohns			

Urinary Function

Bladder infections or UTI		Blood in urine		Wake at night to urinate	
Kidney infections		Cloudy urine		Frequency	
Pain when urinating		Decrease in urinary flow		Night time incontinence	
Urgency		Unable to hold urine			

Gynecological/Reproductive

Vaginal dryness		Fibrocystic breast tissue		Painful menstruation	
Endometriosis		Infertility		PMS	
Vaginal sores		Polycystic Ovarian Disease		Vaginal discharge	
Uterine Fibroids		Irregular menstruation		Ovarian cysts	

Do you practice birth control?_____ What type?_____ How long?_____

Age at first menses	# of days between menses	Duration of menses	Date of last period
Date of last PAP	# of pregnancies	# of births	Age of menopause

Body Temperature

Cold hands		Hot body temperature		Profuse perspiration	
Cold feet		Cold body temperature		Perspire easily	
Sweaty palms		Hot flashes		Lack of perspiration	
Sweaty feet		Afternoon flushing		Climate Preference	
Fevers		Chills		Spontaneous sweating	

Skin and Hair

Rashes		Hives/Allergic Dermatitis		Eczema/Psoriasis	
Ulcerations		Itching		Dandruff	
Loss of hair		Recent moles		Skin discoloration	
Acne		Change in skin/hair texture		Face flushing	
Cracking Skin		Warts		Fungal Infection	
Weak or ridged nails		Dry/Flakey skin		Oily Skin	

Neurological Function

Stroke or CVA or TIA		Difficulty concentrating		Depression	
Paralysis		Irritability		Panic Attacks	
Poor Balance		Aggressive/Bad temper		Concussion	
Poor memory		Anxiety		Depression	
Seizure		Numbness		Tremors	

Musculoskeletal

Neck pain		Shoulder pain		Hand/wrist pain	
Carpal Tunnel		Knee pain		Sprains/Strains	
Sciatica		Foot/ankle pain		Hip pain	
Muscle pain		Muscle weakness		Tendonitis	
Localized Weakness		Bursitis		Rotator Cuff	
Back pain Low___ Middle___ Upper___					

What makes your pain better?

What makes your pain worse?

Please indicate onset: □Sudden □Slow □Gradual

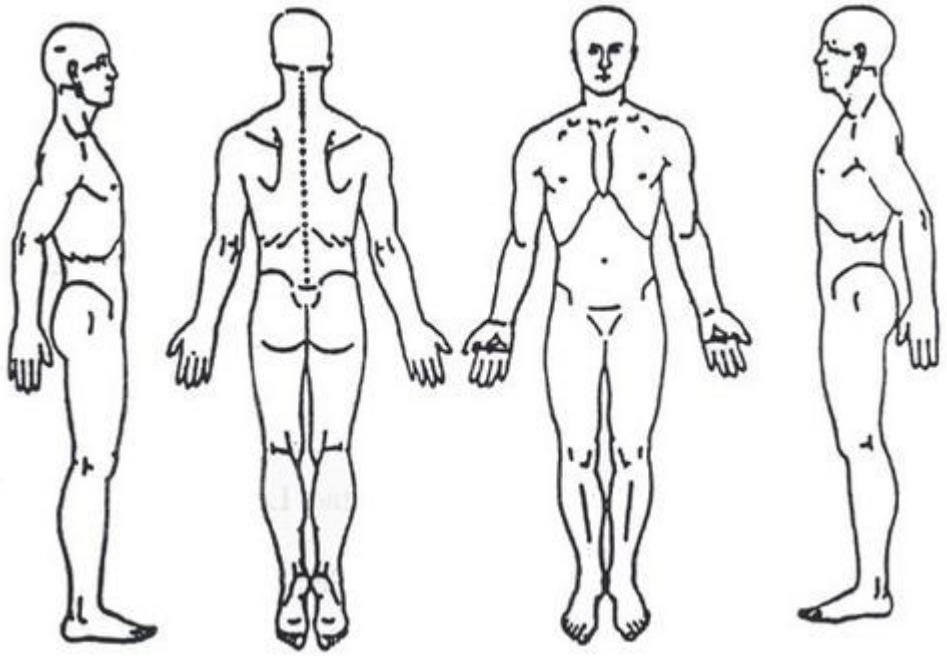
How often do you experience pain: □0-25% □25-50% □50-75% □75-100%

How would you describe the pain: □Achy □Throbbing □Dull □Pins & needles □Moving

□Sharp □Fixed □Heavy □Numbness □Tight

Do you experience : □Cramping/Spasm □Tremors

Please indicate areas of pain, discomfort or limited range of motion by circling or shading



Please list Accidents, Surgeries and Hospitalizations with dates:

Date	Surgery/Hospitalization/Accident

CONSENT FOR TREATMENT

Please read the following carefully and ask your practitioner if there is anything you do not understand.

I, or the person listed below, have discussed with Chelsea Raney R.TCM.P the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

- I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, laser-puncture, electrical stimulation of needles, cupping or moxibustion, gua sha, and tui na. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
- My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
- The herbs and nutritional supplements (which are from plant 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 gastro-intestinal reactions to the herbs I will inform Chelsea Raney R.TCM.P *immediately.*
- I will inform my practitioner if I currently have or develop any major health issues, if I become pregnant, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
- I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
- I understand that there are no guarantees for the results of treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
- I am responsible for the full and prompt payment for services rendered.
- I have discussed the content of this form with Chelsea Raney R.TCM.P. I have been informed that I have a right to refuse any form of treatment. I acknowledge that I have had an opportunity to ask questions about its content. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

_____

Patient's Name

_____

Patient's Signature

_____

Date Signed

_____

Practitioner's Signature

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

_____

Name of Patient

_____

Name of Patient's Representative

_____

Relationship to Patient