



Dr Jackie Zhang DC, RAc

Doctor of Chiropractic and Registered Acupuncturist

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Email: Info@zhangacupuncture.ca

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, low level laser therapy, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions. In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred, or carried out at this practice.

Patient Signature



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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask.

PERSONAL INFORMATION

Name: _____ Date: _____

Home Address: _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Email Address: _____

Occupation: _____ Person Responsible for your account: _____

Who should we thank for referring you to this office? _____

Sex: _____ Male _____ Female Height _____ Weight _____ Birthdate _____ Age _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed

Number of children _____

Have you received acupuncture therapy before? _____ Yes _____ No

If yes, when? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

| Illness | You | Your Relative | Approx. Date | Illness | You | Your Relative | Approx. Date |
|---------------------|--------------------------|--------------------------|--------------|---------------------|--------------------------|--------------------------|--------------|
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Diabetis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Emotional Disorders | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Infectious Diseases | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Sexually transmitted Diseases: Gonorrhea Syphilis AIDS HPV Chlamydia
 Herpes Date _____

| Medicine | Dosage | Reason | How long? | Prescribed by | Date of last check-up |
|----------|--------|--------|-----------|---------------|-----------------------|
| | | | | | |
| | | | | | |
| | | | | | |

Please indicate the use and frequency of the following:

| | | | | | | | |
|-------------------|--------------------------|--------------------------|-----------|---------|--------------------------|--------------------------|-----------|
| | Yes | No | How much? | | Yes | No | How much? |
| Coffee/black tea | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Water Intake | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Soda | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Non-Medical Drugs | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

What are the main health problems for which you are seeking treatment?

What forms of treatment have you sought?

List any other health problems you now have

List any allergies, food sensitivities or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab results (please include copies).

How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

| | Great | Good | Fair | Poor | Bad | Your Comments |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------|
| Significant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Family | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Self | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Spirituality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

FOR WOMEN

Age of 1st period (menarche) _____ Are you pregnant Yes No # of pregnancies _____

Age of last period _____ # of live births _____ # of live abortions _____ # of miscarriages _____
(menopause)

Number of days between periods _____ Date of last: Gynecologic Exam _____ Pap Smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color Flow _____ Result _____

Clots? Yes No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____

4th day _____ 5th day _____

Have you been diagnosed with: Fibrocystic Breast Endometriosis Ovarian Cyst

PID Other _____

Location of Pain (indicate before, during or after menses):

Cramping _____ Consistent _____ Bloating _____

Burning _____ Bearing down sensation _____ Intermittent _____

Dull _____ Stabbing _____

Other symptoms related to menses

- | | | |
|---|--|--|
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Viginal Dryness | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Swollen Breast | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Revenous appetite |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Night Sweats |

FOR MEN

Date of last checkup _____ PSA result _____ Manual prostate exam result _____

Lab result _____

Frequency urination daytime _____ Nighttime _____ Color of urine Clear Murky odor _____

Symptoms related to prostate

- | | | | | |
|---|--|---|--|------------------------------------|
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> delayed stream | <input type="checkbox"/> dribbling | <input type="checkbox"/> incontinence | <input type="checkbox"/> impotence |
| <input type="checkbox"/> rectal dysfunction | <input type="checkbox"/> increase libido | <input type="checkbox"/> decreased libido | <input type="checkbox"/> premature ejaculation | other _____ |
| <input type="checkbox"/> back pain | <input type="checkbox"/> grain pain | <input type="checkbox"/> testicular pain | <input type="checkbox"/> retention of urine | _____ |

SYMPTOMS SURVEY (FOR EVERYONE)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

blank () = never experience check mark (✓) = sometimes experience plus sign (+) = frequently experience

- | | | | | |
|--|--|---|--------------------------------------|--------------------------------------|
| _____ lack of appetite | _____ nightmares | _____ bronchitis | _____ low back pain | _____ intolerance to weather changes |
| _____ excessive appetite | _____ mentally restless | _____ colitis or diverticulitis | _____ knee problems | _____ hearing impairment |
| _____ loose stool or diarrhea | _____ laughing for no apparaent reason | _____ constipation | _____ ear ringing | _____ Allergies |
| _____ digestive problems, indigestion | _____ agina pains | _____ hemorrhoids | _____ kidney stones | _____ high fever |
| _____ vomiting | _____ abdominal pain | _____ recent use of antibiotics | _____ hair loss | _____ dizziness |
| _____ belching, burping | _____ chest pain | _____ urinary problems | _____ tendency to faint easily | _____ high cholesterol level |
| _____ heartburn/reflux | _____ sciatic pain | _____ eye problems | _____ fatigue | _____ blood in stool |
| _____ feeling of retention of food in the stomach | _____ headaches | _____ jaundice (yellowish eyes or skin) | _____ edema | _____ black tarry stool |
| _____ tendency to become obsessive in work, relationship | _____ pain or coldness in the genital area | _____ difficulty digesting oily foods | _____ blood in stool | _____ easily bruised |
| _____ cough | _____ shortness of breath | _____ gall stones | _____ black tarry stool | _____ sudden weight loss |
| _____ insomnia, difficulty sleeping | _____ decrease sense of smell | _____ light colored stool | _____ easily bruised | _____ difficult to stop bleeding |
| _____ heart palpitations | _____ nasal problems | _____ soft or brittle nails | _____ difficult to stop bleeding | _____ asthma |
| _____ cold hands and feet | _____ skin problems | _____ easily angered or agitated | _____ asthma | _____ tendency to catch colds easily |
| _____ feeling of claustrophobia | _____ feeling of claustrophobia | _____ difficulty in making plans or decisions | _____ tendency to catch colds easily | |
| | | _____ spasm or twitching of muscles | | |