

Please take a few moments to fill out this questionnaire carefully. All answers will be held strictly confidential. If you have any questions, please ask us. ***Please fill in first 5 pages only.*** Thank you.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex: M / F Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone No.: (\_\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 How did you find us? Referred by: \_\_\_\_\_  Media  Ad  Street signs  Other

**Personal and Family Medical History**

Check those that apply:	Yourself	Mother	Father	Grandparents	Brother	Sister	Children
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer (note type)							
COPD / Emphysema							
Depression							
Diabetes							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
Hepatitis							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Mental Illness							
Headaches							
Pneumonia							
Stroke							
Thyroid disorder							
Tuberculosis							
Ulcers							
Other							

List any surgeries that you've had (Include the year of the surgery): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please list all medications and supplements you are taking, including length of use:**

**Medications** (please give name, dose and amount of time on med)

Med _____	Dose _____	Length of use? _____
Med _____	Dose _____	Length of use? _____
Med _____	Dose _____	Length of use? _____
Med _____	Dose _____	Length of use? _____

Supplements/Vitamins/Herbs

Name/brand _____	Dose _____	Length of use? _____
Name/brand _____	Dose _____	Length of use? _____
Name/brand _____	Dose _____	Length of use? _____
Name/brand _____	Dose _____	Length of use? _____

**Inquiry**

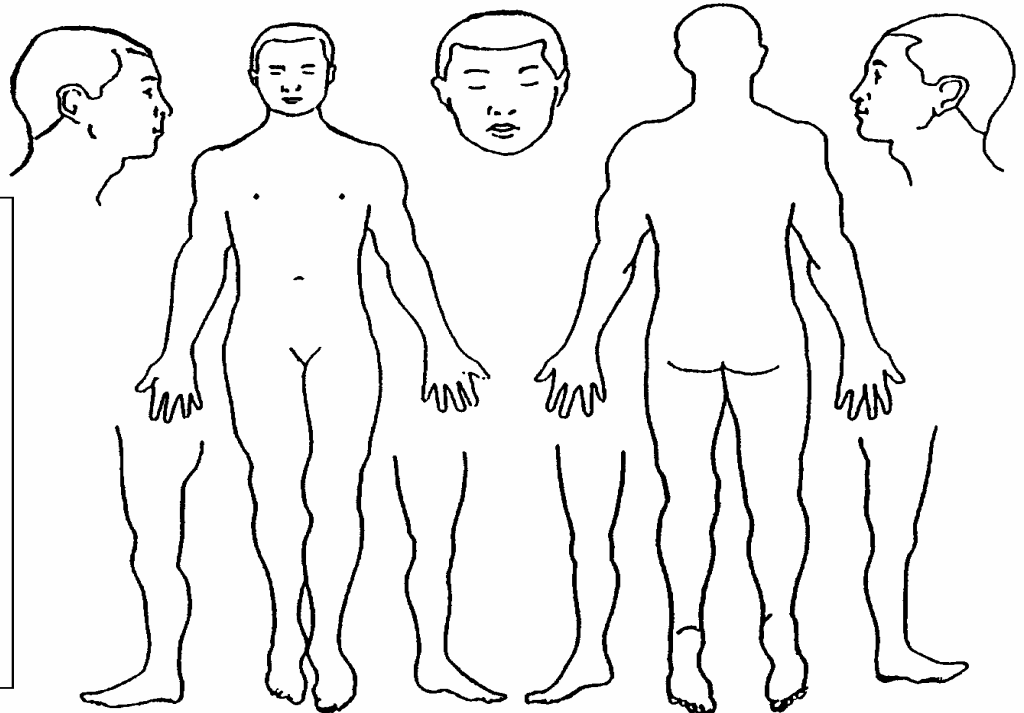
**Chief Complaint:** \_\_\_\_\_

**History of the Present Disease**

Onset of present condition: \_\_\_\_\_

Diagnosis by family physician: \_\_\_\_\_

Location of pain and discomfort:



<b>Symbols</b>	
<b>Pain/pressure</b>	<b>X</b>
<b>Swelling</b>	<b>( )</b>
<b>Tension</b>	<b>+</b>
<b>Weakness</b>	<b>-</b>
<b>Pulsing</b>	<b>*</b>
<b>Sore</b>	<b>O</b>
<b>Rashes</b>	<b>#</b>
<b>Spasm</b>	<b>→ ←</b>
<b>Temp. Cold</b>	<b>↓</b>
<b>Hot</b>	<b>↑</b>

**Pain:**

- |                                    |          |          |                                     |          |          |  |          |          |           |                                       |
|------------------------------------|----------|----------|-------------------------------------|----------|----------|--|----------|----------|-----------|---------------------------------------|
| <b>1</b>                           | <b>2</b> | <b>3</b> | <b>4</b>                            | <b>5</b> | <b>6</b> | <b>7</b>   | <b>8</b> | <b>9</b> | <b>10</b> | (1 = Minimal pain, 10 = Extreme pain) |
| <input type="checkbox"/> Dull      |          |          | <input type="checkbox"/> Burning    |          |          | <input type="checkbox"/> Contracting                 |          |          |           |                                       |
| <input type="checkbox"/> Lingering |          |          | <input type="checkbox"/> Stabbing   |          |          | <input type="checkbox"/> Aggravated / Alleviated by: |          |          |           |                                       |
| <input type="checkbox"/> Sharp     |          |          | <input type="checkbox"/> Distending |          |          | Pressure   | Temp     | Climate  |           |                                       |

**Head and Body:**

- |                                     |  |                                     |       |
|-------------------------------------|--|-------------------------------------|-------|
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Weak limbs | _____ |
| <input type="checkbox"/> Migraines  | <input type="checkbox"/> Back pain     | <input type="checkbox"/> Numbness   | _____ |
| <input type="checkbox"/> Body aches | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Heaviness  | _____ |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle pains  | <input type="checkbox"/> Stiffness  | _____ |

**Cold and Heat:**

- |  |                                    |                                 |       |
|--|------------------------------------|---------------------------------|-------|
| <input type="checkbox"/> Tidal Fever     | <input type="checkbox"/> Cold back | <input type="checkbox"/> Clammy | _____ |
| <input type="checkbox"/> Cold            | <input type="checkbox"/> Chills    | hands/feet                      | _____ |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Heat      | <input type="checkbox"/> Fever  | _____ |

**Sweating:**

- |  |                                      |                                       |       |
|--|--------------------------------------|---------------------------------------|-------|
| <input type="checkbox"/> Spontaneous   | <input type="checkbox"/> No sweating | <input type="checkbox"/> Local sweats | _____ |
| <input type="checkbox"/> With exertion | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats | _____ |

**Energy:** \_\_\_\_\_ **Hrs/night** (1 = Minimal energy, 10 = Maximal energy)

- |   |                                    |  |       |
|---|------------------------------------|--|-------|
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Dyspnea / SOB | _____ |
| <input type="checkbox"/> Fatigues easily    | <input type="checkbox"/> Excess    | <input type="checkbox"/> Fainting      | _____ |
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Drowsy    | <input type="checkbox"/> Heavy feeling | _____ |

**Sleep:** \_\_\_\_\_ **Hrs/night**

- |   |  |                                       |       |
|---|--|---------------------------------------|-------|
| <input type="checkbox"/> Sound, restful | <input type="checkbox"/> Heavy sleep     | <input type="checkbox"/> Not restful  | _____ |
| <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Dream disturbed | <input type="checkbox"/> Grinds teeth | _____ |

**Urine:**

- |                                       |                                     |                                 |       |
|---------------------------------------|-------------------------------------|---------------------------------|-------|
| <input type="checkbox"/> Normal       | <input type="checkbox"/> Nocturia   | <input type="checkbox"/> Clear  | _____ |
| <input type="checkbox"/> Polyuria     | <input type="checkbox"/> Infrequent | <input type="checkbox"/> Dark   | _____ |
| <input type="checkbox"/> Urgency      | <input type="checkbox"/> Dysuria    | <input type="checkbox"/> Excess | _____ |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Hematuria  | <input type="checkbox"/> Scanty | _____ |

**Stool:**

- |                                       |                                       |                                    |       |
|---------------------------------------|---------------------------------------|------------------------------------|-------|
| <input type="checkbox"/> Regular      | <input type="checkbox"/> Loose/watery | <input type="checkbox"/> Dry, hard | _____ |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Foul smell   | <input type="checkbox"/> Burning   | _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas          | <input type="checkbox"/> Explosive | _____ |

**Thirst:**

- |   |  |  |       |
|---|--|--|-------|
| <input type="checkbox"/> Thirsty with desire to drink | <input type="checkbox"/> Likes hot drinks                | <input type="checkbox"/> Dry mouth             | _____ |
| <input type="checkbox"/> Likes cold drinks            | <input type="checkbox"/> Thirsty with no desire to drink | <input type="checkbox"/> Bitter taste in mouth | _____ |
|   |  | <input type="checkbox"/> Metal taste in mouth  | _____ |

**Appetite:**      0      1      2      3      4      5      (0 = No appetite, 5 = Heavy appetite)

- |   |                                   |   |       |
|---|-----------------------------------|---|-------|
| <input type="checkbox"/> Cravings       | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heartburn        | _____ |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Gas      | <input type="checkbox"/> Bad Breath       | _____ |
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Bloating | <input type="checkbox"/> Food Preferences | _____ |

**Emotions:**

- |                                       |                                    |                                       |       |
|---------------------------------------|------------------------------------|---------------------------------------|-------|
| <input type="checkbox"/> Calm/relaxed | <input type="checkbox"/> Angry     | <input type="checkbox"/> Grief        | _____ |
| <input type="checkbox"/> Depressive   | <input type="checkbox"/> Irritable | <input type="checkbox"/> Overthinking | _____ |
| <input type="checkbox"/> Anxious      | <input type="checkbox"/> Stressed  | <input type="checkbox"/> Fearful      | _____ |

**Lifestyle and Body Type:**

- |   |   |   |       |
|---|---|---|-------|
| <input type="checkbox"/> Smoking            | <input type="checkbox"/> Irregular hours  | <input type="checkbox"/> Alcohol                      |       |
| <input type="checkbox"/> Weight gain / loss | <input type="checkbox"/> Shift work       | <input type="checkbox"/> Caffeine                     |       |
| <input type="checkbox"/> Thin / Heavy       | <input type="checkbox"/> Regular Exercise | <input type="checkbox"/> Occupational stress factors: | _____ |

**Eyes:**

- |   |                                    |                                  |       |
|---|------------------------------------|----------------------------------|-------|
| <input type="checkbox"/> Blurry vision          | <input type="checkbox"/> Eye pain  | <input type="checkbox"/> Burning | _____ |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Eyestrain | <input type="checkbox"/> Red     | _____ |
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Dry eyes  | <input type="checkbox"/> Yellow  | _____ |

**Ears:**

- |                                       |                                   |                                   |       |
|---------------------------------------|-----------------------------------|-----------------------------------|-------|
| <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Earaches | _____ |
|---------------------------------------|-----------------------------------|-----------------------------------|-------|

**Skin and Hair:**

- |                                   |                                      |   |       |
|-----------------------------------|--------------------------------------|---|-------|
| <input type="checkbox"/> Rashes   | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Dandruff             | _____ |
| <input type="checkbox"/> Itching  | <input type="checkbox"/> Eczema      | <input type="checkbox"/> Hair loss            | _____ |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Hives       | <input type="checkbox"/> Changes in skin/hair | _____ |

**Gynecology:**

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Regular    | <input type="checkbox"/> Clots              | <input type="checkbox"/> Discharge: _____ |
| <input type="checkbox"/> Irregular  | <input type="checkbox"/> Heavy / Light flow | <input type="checkbox"/> PMS              |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Pale / Dark colour | <input type="checkbox"/> Pain _____       |

Age at first period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_

Time between cycles: \_\_\_\_\_ Duration of bleeding: \_\_\_\_\_ First day of last period: \_\_\_\_\_

Oral contraceptive use: \_\_\_\_\_ Type: \_\_\_\_\_ For how long: \_\_\_\_\_

**Other Health Concerns:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Informed Consent for Traditional Chinese Medicine Treatment

*You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please ask your attending traditional Chinese medicine practitioner to further explain it all pertinent information's in regards to your traditional Chinese medicine treatment. You may also seek a second opinion from another health care professional, or terminate therapy at any time.*

I hereby request and consent to the performance of traditional Chinese medicine treatments and other procedures within the scope of the practice of traditional Chinese medicine on me by the **Zoran Jelcic, TCMP, R.Ac**, a traditional Chinese medicine practitioner named below who works at Nourished Health clinic.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping therapy, Chinese herbal medicine, and electrical stimulation of the acupuncture needles, moxibustion, infrared heat use, Chinese medical nutrition and traditional Chinese medicine counseling, Chinese medical qigong and Chinese manual medicine (soft tissue manipulation and/or joint manipulation).

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is an also common side effect of cupping therapy. The **Zoran Jelcic, TCMP, R.Ac** uses sterile disposable needles and maintains a clean and safe environment at Nourished Health clinic.

I understand that a minority of patients may notice stiffness or soreness after the first few days of treatment by Chinese manual medicine. I understand and am informed that, as in the practice of traditional Chinese medicine, acupuncture and in the practice of Chinese manual medicine there are some risks to treatment, including but not limited to strains, bruising and local pain.

The traditional Chinese medicine herbs (which are from plant, and mineral sources) that have been recommended are traditionally considered safe in the practice of traditional Chinese medicine (TCM) and Acupuncture, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the traditional Chinese medicine practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that some herbs may be inappropriate during pregnancy. Therefore, I will notify the traditional Chinese medicine practitioner who are caring for me if I am or become pregnant.

I do not expect the traditional Chinese medicine practitioner to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the traditional Chinese medicine practitioner to exercise judgment during the course of treatment which the traditional Chinese medicine practitioner thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

**By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of the traditional Chinese medicine therapies and procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Zoran Jelcic, TCMP, R.Ac.**

Patient's Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**FOR TRADITIONAL CHINESE MEDICINE PRACTITIONER USE ONLY.**

**Inspection, Auscultation, and Olfaction**

**GENERAL INSPECTION:** \_\_\_\_\_

**Shen:**

- |                                 |                                    |                                       |
|---------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bright | <input type="checkbox"/> Deficient | <input type="checkbox"/> Nervous      |
| <input type="checkbox"/> Dull   | <input type="checkbox"/> Excess    | <input type="checkbox"/> Tics/Tremors |

Overall Impression: \_\_\_\_\_

**Complexion:**

- |                                 |                                      |                                       |
|---------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sallow | <input type="checkbox"/> Flushed     | <input type="checkbox"/> Dry skin     |
| <input type="checkbox"/> Dim    | <input type="checkbox"/> Malar Flush | <input type="checkbox"/> Dark Circles |
| <input type="checkbox"/> Pale   | <input type="checkbox"/> Red         |                                       |

**LOCAL INSPECTION:** \_\_\_\_\_

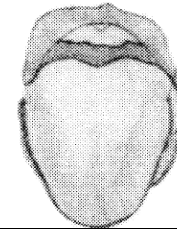
**AUSCULTATION:** \_\_\_\_\_

- |                                     |  |  |   |
|-------------------------------------|--|--|---|
| <input type="checkbox"/> Weak voice | <input type="checkbox"/> Talks rapidly | <input type="checkbox"/> Rapid breathing | <input type="checkbox"/> Wheezing           |
| <input type="checkbox"/> Loud voice | <input type="checkbox"/> Talks slowly  | <input type="checkbox"/> Sighs a lot     | <input type="checkbox"/> Rattling in throat |

**OLFACTION:** \_\_\_\_\_

**Tongue**

Body: \_\_\_\_\_  
 Color: \_\_\_\_\_  
 Coat: \_\_\_\_\_  
 Other Qualities: \_\_\_\_\_



**Palpation**

- |       |                                |                                      |               |                |
|-------|--------------------------------|--------------------------------------|---------------|----------------|
| PULSE | <input type="checkbox"/> Full  | <input type="checkbox"/> Empty       | <u>LEFT :</u> | <u>RIGHT :</u> |
|       | <input type="checkbox"/> Rapid | <input type="checkbox"/> Slow        | HT            | LU             |
|       | <input type="checkbox"/> Long  | <input type="checkbox"/> Short       | LV            | SP             |
|       | <input type="checkbox"/> Deep  | <input type="checkbox"/> Superficial | KI-Yin        | KI-Yang        |

Pulse Overall Impression: \_\_\_\_\_

**TCM Diagnosis**

TCM Disease Diagnosis: \_\_\_\_\_

Primary Syndrome Diagnosis: \_\_\_\_\_

Secondary Syndrome: Diagnosis: \_\_\_\_\_