Patient Health Summary (Sample form A)

Clinic Name/Practitioner Name/Registration #

Clinic Address and Phone Number

Patient Information			
Last name:		**First Name:**	**Middle Name:**
Birth Name/Other Previous Names:			**Gender:** F / M / Other
Home Address:			**Date of Birth: (DD/MM/YY)**
City:	**Province:**	**Postal Code:**	**Marital Status:**
Phone:		**Mobile:**	**Occupation:**
Fax:		**Email:**	

Family Contact Information		
First name:		**Last name:**
Relationship to Patient:	**Phone Number:**	**Mobile Number:**

Emergency Contact information (If different from above)		
First name:		**Last Name:**
Relationship to Patient	**Phone Number:**	**Mobile Number:**

Family Doctor Contact Information			
Family Doctor Name:			
Address:			**Additional Notes:**
City:	**Province:**	**Postal Code:**	
Phone:	**Fax:**	**Email:**	

Past Medical History

☐ Mumps ☐ Herpes ☐ Hepatitis ☐ HIV+ ☐ Osteoporosis ☐ Tumor ☐ Measles
☐ High Blood Pressure (Hypertension) ☐ Low Blood Pressure (Hypotension) ☐ Stroke
☐ Fracture ☐ Arthritis ☐ Gout ☐ Diabetes ☐ Tuberculosis ☐ High Cholesterol
☐ Muscle Sprain ☐ Cancer
☐ Other:

Risk Factors

Allergies/Drug Reactions

☐ Penicillin ☐ Peanut ☐ Dust ☐ Pollen ☐ Dairy ☐ Gluten ☐ Wheat ☐ Chocolate ☐ Caffeine
☐ Other:

Ongoing Health Conditions

- ☐ Headache
- ☐ Fatigue
- ☐ Plantar Fasciitis
- ☐ Tingling in Legs
- ☐ High Blood Pressure
- ☐ Pinched Nerves in Back or Neck
- ☐ Other:
- ☐ Neck Pain
- ☐ Jaw Pain
- ☐ Bowel Problem
- ☐ Tingling in Arms
- ☐ Lower Back Pain
- ☐ Asthma
- ☐ Depression
- ☐ Dizziness
- ☐ Knee or Hip Pain
- ☐ Slipped Disc
- ☐ Mid Back Pain
- ☐ Arthritis
- ☐ Memory Loss
- ☐ Poor Posture
- ☐ Carpal Tunnel
- ☐ Menstrual Problem
- ☐ Stomach Problem
- ☐ Heart Palpitation
- ☐ Allergies

Long Term Treatment

Date of Last Update:						**Signature:**

Patient Health Record (Sample Form B)
Clinic Name/Practitioner Name/Registration #
Clinic Address and Clinic Phone Number

PATIENT HEALTH HISTORY

Personal Health and Medical history
(Ongoing problems, past illnesses, operations, allergies, drug reactions, prescription medications, herbal supplements, vitamins, over the counter remedies)

Family Health History

☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Thyroid Problems ☐ Multiple Sclerosis
☐ Stroke
☐ Others:

Referral Diagnosis

Practitioner:	**Date:**	**Signature:**

INITIAL ASSESSMENT

Presenting Symptom/Chief Complaint

Main Signs and Symptoms

Other Signs and Symptoms

TCM Diagnosis and Treatment (identified TCM disease, TCM differentiation of syndromes)

Treatment Principles and Strategies

Treatment Plan (Modalities; acupuncture, herbal, dietary, manual therapies), frequency and duration

Any Other Advice Given to Patients

Practitioner:	**Date:**	**Signature:**

FOLLOW-UP TREATMENT

Date of Last Visit :	Date of Follow-Up Treatment:

Progress Inquiry

TCM Differential Diagnosis (not required for each visit)

Treatment Plan Modification

Contraindications

Herbal Medicine Prescription	Acupuncture Prescription

Adjunct Modalities/Treatment or Procedures Used

Patient Reactions

Practitioner:	Date:	Signature:

Referring Health Care Provider			
Referring Health Care Provider:			
Address:			**Additional Notes:**
City:	**Province:**	**Postal Code:**	
Phone:	**Fax:**	**Email:**	
Other Relevant Care Provider			
Name of Care Provider:			
Address:			**Additional Notes:**
City:	**Province:**	**Postal Code:**	
Phone:	**Fax:**	**Email:**	

Attach any Tests/Reports below:

Patient Informed Consent to Treatment (Sample Form C)
Clinic Name/Practitioner Name/Registration # Clinic Address
Clinic Phone Number

I, or the person listed below, have discussed with my traditional Chinese medicine practitioner or acupuncturist 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.

1. 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, the electrical stimulation of needles, cupping or moxibustion, gua sha, and Tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. 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.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. 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.
5. 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.
6. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

_____ _____

Patient Signature Practitioner Signature

_____ _____

Date Date

Consent to Collect and Release Information (Sample Form D)
Clinic Name/Practitioner Name/Registration # Clinic Address
Clinic Phone Number

I_____, or my appointed representative_____
(Print) (Print)

❑ Consent ❑ Do not consent

for Clinic _____ to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.

In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used
Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist third-party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to information
I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records be limited are:

- cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

[If applicable] I understand that a reproduction or translation fee may be incurred in accordance with the clinic's fee schedule.

Acknowledgment
I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions: _____
_____
_____

_____ _____
Patient Signature Witnessed

_____ _____
Date Date

Patient Billing (Sample Form E)

Clinic Name/Practitioner Name/Registration # *Clinic Address and Clinic Phone Number*			
Practitioner / Registration Number		Invoice Number	
Patient Name		Invoice Date	

Items		**Amount**
Service/Procedure Received		
		$
		$
Equipment Used	**Date Equipment Used**	
		$
		$
		$
		$
Prescriptions and All Other Natural Health Products Sold		
		$
		$
		$
		$
Any Other Products Sold		
		$
		$
	Total:	$

Equipment and Supplies Record (Sample Form F)

Clinic Name/Practitioner Name/Registration # *Clinic Address and Clinic Phone Number*			
Equipment / Supply	**Date Equipment Purchased**	**Date Equipment Decommissioned**	**Service Notes (if applicable)**

TCM Herbal Inventory Record (Sample Form G)

Clinic Name/Practitioner Name/Registration # *Clinic Address and Clinic Phone Number*				
TCM Herbal Name, Herbal Medicine Name and/or Natural Product Number (NPN)	**LOT Number**	**Date Purchased**	**Date of Expiry**	**Service Notes (if applicable)**