Dr. Tanya Kelloway, R.Ac., D.T.C.M., R.M.T.
Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Alternative medicine procedures on me (or on the patient named below, for which I am legally responsible) by Tanya Kelloway, registered acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, supplements, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal 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 the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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.
________ Initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.
________ Initials

____
Patient's Name

____
Patient's Signature

____
Date Signed

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

Name of Patient's Representative

____

Signature

____

Relationship to Patient

____

Witness Signature

____

Dr. Tanya Kelloway, R.Ac., D.T.C.M., R.M.T.

Acupuncture Fee Schedule

Please read carefully and sign below.

Acupuncture Assessment (1st Visit): Initial consultation and examination $147.00

Acupuncture Treatment $94.50

Acupuncture Package (6 treatments) **$504.00**

I agree I am responsible for these payments.

I understand that all payments are due at the time of service.

I understand that I will be charged a $45 "missed appointment fee" for any missed appointments or appointments cancelled with less than 24 hours notice.

As a courtesy to other patients and your practitioner, please try to be on time for your appointment. If you will not be on time, please call and advise reception. Due to your practitioner's time sensitive schedule, if you are late for your appointment, the practitioner will only see you until your scheduled end time. You will still be charged the full fee for the appointment.

Signature:____ Date:____________________

Patient Confirmation of Consultation with Primary Physician

Please read carefully and sign below

Alberta acupuncture legislation states that an acupuncturist must not treat someone who has not consulted with a primary care physician or, in the case of dental pathology, a dentist about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable box confirming that you already have seen a physician, or will be seeing one within two weeks of your first acupuncture treatment.

I have already seen a primary care physician (Western Medical Doctor) regarding the condition(s) that I am seeking treatment for.

I agree to see a doctor regarding the condition(s) that I am seeking treatment for within two weeks of my first acupuncture treatment at Mount Royal Health Center.

Patient Signature:____ Date:________________________

Witness Signature:____ Date:________________________

Acupuncture Intake

Dr. Tanya Kelloway, R.Ac., D.T.C.M.

Name:______________________________________ Birth date: (mm/dd/yyyy)____________________

Marital Status: _______________ Occupation:____

Address:____

City:___________________________ Province: ________ Postal Code:__________________________

Primary Phone #: ___________________________ Secondary Phone #_____________________________

Email Address: ____

May we contact you by email? □ Yes □ No

Would you like to receive our complimentary Monthly Health newsletters? □ Yes □ No

Emergency Contact Name:___________________________ Phone #: ___________________________

Physician's Name: _________________________________ Phone #: ___________________________

Who may we thank for referring you? ____

Reason for visit: ____

Initial Cause: ____

How long have you experienced these symptoms? _______________Are they getting worse? □ Yes □ No

What makes them feel better? ____

What makes them feel worse? ____

Does it affect your: □ Sleep □ Work □ Other (please describe): _______________________________

Have you ever had acupuncture before? □ Yes □ No

What other therapies have you tried for your health concern?__________________________________

What has worked?____

What do you expect from your visits with Dr. Tanya Kelloway? ____________________________________

____

Do you have, or have you ever had:

□ AIDS □ Hepatitis A □ Hepatitis B □ Hepatitis C □ Hemophilia

Are you on blood thinners? □ Yes □ No

Do you have a pacemaker or metal implants? □ Yes □ No

Please list any pharmaceuticals that you have taken in the last 2 months:

____

Please list any vitamins or supplements that you have taken in the last 2 months:

____

Do you consume recreational drugs or alcohol? □ Yes □ No

If so, please list the type and amount consumed per week: ____________________________

How often do you exercise? ____________________________

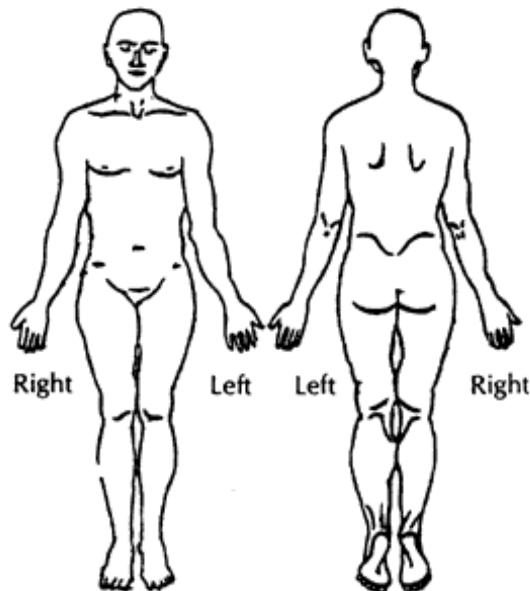
What type of exercise do you do? ____________________________

Please list any accidents, injuries or traumas that you have experienced:

____
____

Blood Pressure: _______ / _______

Please circle any areas of <u>pain and discomfort</u>, including numbness and tingling.



Rate your pain on a scale of 1-10 (1= Mild pain, 10= Worst pain you have ever experienced) : ____________________

Headaches How often do you experience headaches? ____

Kind of pain: □ Distention □ Burning □ Prickling □ Dull/ Achy □ Heavy

Location of headache: □ Front □ Back □ Top □ Whole head □ Sides

Rate your pain on a scale of 0-10 (0=no pain, 10= worst pain you have ever experienced): _______________

Emotions

Are you frequently in a state of:

□ Anger/ Frustration □ Anxiety/ Pensiveness □ Sadness □ Fear □ Over joy

Have you or are you experiencing a chronic or acute emotional issue that is affecting your life? Please describe:

____

____

____

Taste

What taste do you have a preference for?

□ Salty □ Sweet □ Bitter □ Sour □ Pungent

Do you consume any artificial sweeteners such as aspartame or Splenda? □ Yes □ No

Food and Drinks

Number of meals per day: ________ What time do you eat your meals: ____________________________________

Describe what you would typically eat for:

Breakfast: ____ Lunch:____

Dinner: ____ Snacks:_______________________________________

How many cups of water do you drink per day: _______ Do you find yourself frequently thirsty? □ Yes □ No

Do you have a preference for: □ Hot drinks □ Cold drinks

Check other beverages you consume and write how many cups per day:

□ Coffee___ □ Tea___ □ Pop___ □ Diet Pop___ □ Juice___ □ Energy Drinks ___ □ Other____

Bowel Movements

Frequency:______________________________________ Texture:____

Color:_______________________________ Odor (normal, strong, ext.):____________________________________

Do you experience frequent: □ Constipation □ Diarrhea

Have you been diagnosed with: □ Irritable Bowel Syndrome □ Ulcerative Colitis □ Chron's Disease

Other (please describe)____

Urination

□ Normal color □ Clear □ Profuse □ Burning □ Dark yellow □ Cloudy □ Scant

□ Strong Odor □ Urgent □ Reddish □ Painful □ Frequent

Sleeping

How many hours of sleep do you get each night? ____

What time do you go to bed?_________________ What time do you get up in the morning? ____________________

Please check off any boxes that apply to you:

□ Trouble getting to sleep □ Trouble staying asleep □ Feel un-refreshed upon awakening □ Sleep paralysis

□ Dream disturbed sleep □ Sleep with your eyes open □ Restless sleep (tossing and turning)

Have you been diagnosed at a sleep clinic with any sleeping disorders? (i.e. Sleep apnea) □ Yes □ No

If so, please describe: ____

Below are several diseases and conditions which may see unrelated to the reason you have come to see Dr. Tanya Kelloway. However, these questions must be answered carefully, as these problems can affect your overall course of care. Please check all that apply to you.

Diseases

□ Rheumatic fever □ Eczema □ Pneumonia □ Thyroid problems □ Small Pox □ Stroke/ TIA

□ Anemia □ Heart disease □ Psoriasis □ Arthritis □ Diabetes □ Cancer □ Tuberculosis

□ Chicken Pox □ Influenza □ Asthma □ Other (describe: ____________________________________)

All of the following are pertaining to a Traditional Chinese Medicine view of the body.

Please check any of the following that pertain to you.

Kidney Function

□ Cold hands □ Cold feet □ Hot body temperature □ Cold body temperature □ Hot flashes

□ Night sweats □ Drinking water before bed or throughout the night □ Sweaty hands □ Sweaty feet

□ Difficulty keeping eyes open during the day □ Heat in hands, feet or chest □ Changed in hair

□ Ear/ hearing problems □ Dental problems □ Clicking jaw □ Low back pain □ Sexual Dysfunction

□ Fertility problems □ Prostate Problems □ Joint pain/stiffness □ Memory problems/ confusion

□ Weak knees □ Sore knees □ Cold sensation in knees □ Waking during the night twice or more to urinate

□ Lack of will power □ Bladder problems (please describe:____)

□ Excess bone growth □ Bones not healing normally after a break

Spleen Function

□ Change in appetite □ Hemorrhoids □ Over thinking □ Pensive/ Nervousness □ Abdominal gas

□ Abnormal weight gain or loss □ Abdominal bloating □ Gurgling in stomach □ Prolapsed organ

□ Easily bruised □ Indigestion □ Inability to adapt to stress □ Fatigue after eating

Stomach Function

□ Large appetite □ Heartburn □ Acid regurgitation □ Ulcer □ Nose bleeds □ Vomiting

□ Bad breath □ Mouth sores (cankers) □ Stomach pain □ Bleeding/ swelling/ painful gums

□ Belching □ Hiccups □ Burning sensation after eating □ Nausea

Lung Function

□ Cough □ Dry mouth □ Dry nose □ Sneezing □ Headache □ Stiffness in shoulder

□ Nasal discharge(color:_______________) □ Nose bleeds □ Stiff neck □ Sore throat

□ Allergies (list:____) □ Difficulty breathing

□ Smoke cigarettes □ Sinus congestion □ Dry throat □ Dry skin □ Overall achiness in body

□ Alternating fevers and chills □ Easily catches colds

Heart Function

□ Palpitation □ Restlessness □ Chest pain □ Anxiety □ Dream disturbed sleep □ Mental confusion

□ Soreness of the tip of the tongue □ Easily startled □ Irregular heart beat □ Perspires easily

□ Lack of perspiration □ Other heart problems (please describe:____)

Liver Function

□ Depression □ Irritability □ Convulsions □ Gallstones (previous or current) □ Angers easily

□ Muscle cramping/ twitching □ Seizures □ High pitched ringing in ears □ Bitter taste in mouth

□ Lack of motivation □ Emotional problems (please describe:____)

□ Eye/ vision problems (please describe:____)

□ Skin rashes (please describe:____)

□ Liver/ Gallbladder problems (please describe:____)

Overall

□ Excess phlegm □ Mental sluggishness/ fogginess □ Feeling in throat that cannot be expelled or swallowed

□ Wandering pain □ Pressure on body/ head □ Excess bone growth □ Sticky feeling in the mouth

□ Generally hot feeling □ Generally cold feeling □ Frequent colds/ flu □ Mental heaviness

□ High energy □ Low energy □ Dislikes speaking □ Feeling of “rushing up” in the body □ Fainting

□ Oppression of the chest □ Lumps under skin □ Edema (swelling) □ Varicose veins □ Dizziness/ Vertigo

Gynecology- **Women Only**

Are you in: □ Peri-menopause □ Menopause □ Post- menopause

Age menses began:______________ Duration of flow (# of days):___________ Length of cycle:_______________

Date of last period:___________________ Date of last PAP: _____________

Is your period regular? □ Yes □ No

If no please describe:____

Please check off any boxes that describe your period: □ Thin □ Thick □ Clots □ Heavy □ Mucus

□ Bright red □ Painful □ Light □ Dark red □ Brown □ Odorous

Do you experience: □ PMS □ Breast pain □ Breast lumps

Do you, or have you, experienced: □ Breakthrough bleeding □ Amenorrhea (no period)

Have you ever had a UTI? □ Yes □No

Are you on birth control? □ Yes □ No What kind?____

Have you ever been pregnant? □ Yes □ No

Are you trying to get pregnant? □ Yes □ No If so, how long have you been trying? _____________________

Have you tried other methods of getting pregnant? If so, what kind? ____

Number of: Live births:________ Premature births:_________ Abortions:_________ Miscarriages: _________

Ectopic Pregnancies_________ Other (Please describe):____

Do you experience: □ Vaginal sores □ Vaginal dryness □ Abnormal vaginal odors □ Vaginal Infections

Is your leucorrhea (vaginal discharge) normal or has it changed? If so, how has it changed

For Men Only

Changes in sexual function can relate to your overall health.

Have you experienced a change in sex drive? □ Increase □ Decrease □ Same

Have you experienced changes in erection strength? □ Increase □ Decrease □ Same

Can you maintain your erection as long as you used to? □ Yes □ No

Have you been experiencing premature ejaculation? □ Yes □ No

Does having sexual intercourse make you tired? □ Yes □ No

Do you go for regular prostate exams? □ Yes □ No

PSA Level _______________

Have you experienced any change in your urine output? □ Yes □ No

□ Frequency □ Starting and Stopping □ Blood in Urine □ Painful Urination

□ Other:____

Have you been experiencing male pattern baldness? □ Yes □ No

Have you ever had a UTI? □ Yes □No