royal treatment THERAPEUTICS

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have any questions, please ask. Thank You.

Name: _____ **Birth Date**: _____ (MM/DD/YYYY)
Address: _____ **Care Card Number:** _____
_____ **Occupation:** _____
Postal Code: _____ **Family Doctor:** _____
Phone: (home): _____ **Phone:** _____
(cell): _____ **Emergency Contact Name:**_____
E-mail Address: _____ **Relationship**: _____ **Phone:** _____
Is this an ICBC Claim? ○ YES ○ NO **If YES, Claim #:** _____
Is this a WCB Claim? ○ YES ○ NO **If YES, Claim #:** _____

How did you hear about us?
☐ Co-Worker ☐ Friend ☐ Family ☐ Internet ☐ Neighborhood ☐ Other

Previous Patient of _____ - Other _____
Do you wish to receive appointment reminders via: ○ Text ○ Email ○ Both?
☐ I agree to grant Royal Treatment Therapeutics permission to send messages. I understand I may unsubscribe at any time.

Have you had Acupuncture or used TCM treatments before? ○ YES ○ NO
When was the last treatment? _____ (YYYY/MM/DD)

WHAT IS THE **PRIMARY REASON** FOR YOUR VISIT TODAY?
_____
_____
SECONDARY COMPLAINTS: _____

When did you ***first notice*** any symptoms? _____
Have you experienced these symptoms before? _____
Is this condition getting: ○ **BETTER** ○ **WORSE** ○ **STAYING THE SAME**
Have you been given a ***diagnosis*** for this condition by another practitioner? ○ YES ○ NO
If YES, what was the diagnosis? _____
Have you received any ***previous treatment*** for this condition? ○ YES ○ NO
If YES, please specify: _____
Is your present condition the result of a single ***traumatic event***? ○ YES ○ NO
If YES, please specify: _____

Royal Treatment Therapeutics
#102 – 7777 Royal Oak Avenue, Burnaby BC, V5J 4K2 | office (604) 437 7777 | fax (604) 437 7789 |
RoyalTreatmentTherapeutics.com

royal treatment
THERAPEUTICS

Please check if you have or had any of the following conditions:

☐ Cancer	☐ Diabetes	☐ Hepatitis
☐ Low Blood Pressure	☐ High Blood Pressure	☐ Blood Clotting Disorder
☐ Liver Disease	☐ Neurological condition	☐ Spinal or Head Injury
☐ HIV/AIDS	☐ Kidney Disease	☐ Seizures
☐ Heart / Lung Disease (including TB)		

Please list all medications (name, dosage) you are currently taking: _____

_____

_____

Do you wear any medically implanted device (i.e. pacemaker, implanted defibrillator)? ○ YES ○ NO

Have you ever had any previous Injuries, Trauma, Surgery or Major Illnesses? ○ YES ○ NO
If YES, please describe:

_____

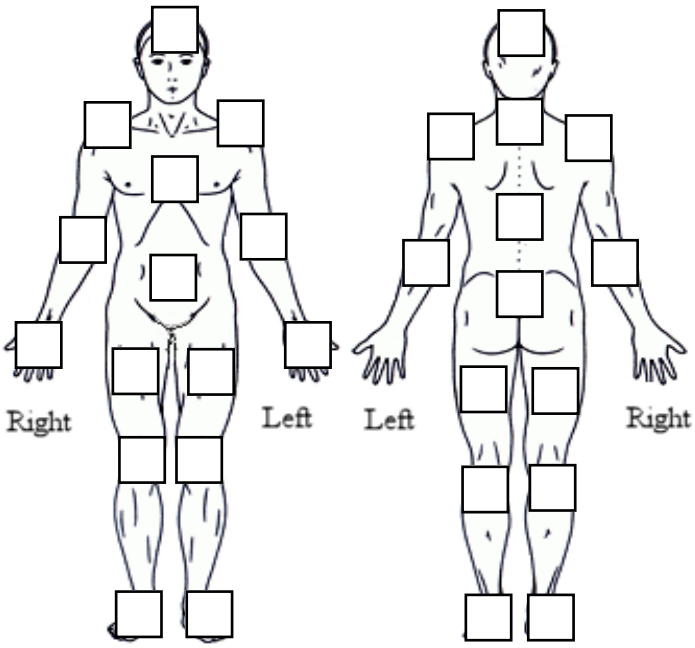
How is your energy? Indicate your level of energy using a scale of 0-10 (where 0 indicates no energy and 10 indicates high energy): _____
Do you fatigue easily? ○ YES ○ NO

MEDICAL HISTORY: (Please indicate all symptoms and signs occurring presently or within the past 12 months)

Muscles/ Bones/ Joints
Do you have pain (Sharp Pain, Dull Aching Pain, Numbness/Pins/Needles) or tightness?
○ YES ○ NO

If YES, use the diagrams to the right to checkmark the area(s) where you feel the described sensations.

NOTE: Please mention any other symptoms during the initial examination.



Royal Treatment Therapeutics
#102 – 7777 Royal Oak Avenue, Burnaby BC, V5J 4K2 | office (604) 437 7777 | fax (604) 437 7789 |
RoyalTreatmentTherapeutics.com

Please rate the intensity of your pain today using a scale of 0-10 (where 0 indicates no pain and 10 indicates excruciating pain): _____

The pain is:

◯ Worse or ◯ Better with **Heat**
◯ Worse or ◯ Better with **Cold**
◯ Worse or ◯ Better with **Pressure**

I have the following: (MARK ALL THAT APPLY)

☐ Swollen Joints ☐ Osteoarthritis/Joint Pain ☐ Rheumatoid Arthritis
☐ Tendonitis ☐ Bursitis ☐ Muscle Cramps
☐ Muscle Pain ☐ Muscle Weakness ☐ Bone Pain
☐ Fractured Bone(s) ☐ Other: _____

Emotions & Sleep

How do you feel emotionally? Do you experience any of the following? (MARK ALL THAT APPLY)

☐ Panic Attacks ☐ Depression ☐ Anxiety ☐ Anger
☐ Nervousness ☐ Poor Memory ☐ Difficult Concentration

How long do you normally sleep? _____ hours per night

I have difficulty with: (MARK ALL THAT APPLY)

☐ Falling asleep ☐ Staying asleep ☐ Dream-disturbed Sleep

Waking up at about (indicate time):_____ AM / PM and not being able to fall asleep again.

Gastrointestinal

I have the following: (MARK ALL THAT APPLY)

☐ Belching ☐ Nausea ☐ Vomiting ☐ Ulcers
☐ Bloating ☐ Heartburn ☐ Hernia ☐ Acid Reflux
☐ Severe Stomach Pain ☐ Other: _____

I have the following: (MARK ALL THAT APPLY)

☐ Irregular Bowel Movements ☐ Constipation ☐ Diarrhea ☐ Undigested Food in Stool
☐ Burning Sensation ☐ Hemorrhoids ☐ Itchiness ☐ Painful Bowel Movements
☐ Hard Stool ☐ Loose Stool ☐ Blood in Stool ☐ Gas

I have the following: (MARK ALL THAT APPLY)

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ IBS ☐ Anal Prolapse
☐ Other: _____

Bowel Movements: How often? _____ time(s)/day OR _____ days/week

Urination
How often? _____ times per day, indicate the Urine Colour: ◯Pale yellow ◯Dark yellow ◯ Orange

I have the following: (MARK ALL THAT APPLY)

- ☐ Trouble starting Stream
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Dribbling when Sneezing/Coughing
- ☐ Burning Pain
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Urinary Tract Infections
- ☐ Other: _____

Women only
Are you pregnant? ◯YES ◯NO
Age of first menses: _____
Days between cycles: _____ Flow days: _____ Typical Colour: ◯Dark red ◯ Purple ◯Bright red ◯Pale red
I have the following: (MARK ALL THAT APPLY)

- ☐ Irregular Menstruation
- ☐ Heavy Flow
- ☐ Light Flow
- ☐ No Flow
- ☐ Clots
- ☐ Vaginal Itching/Burning
- ☐ Spotting between Periods
- ☐ Discomfort/Pain before Period
- ☐ Irritability
- ☐ Breast Tenderness
- ☐ Cravings
- ☐ Cramps
- ☐ Vaginal Prolapse

Do you have Vaginal Discharge? ◯YES ◯NO If YES, what is the colour: _____
Number of Pregnancies: _____ Number of Children: _____

Men only
I have the following: (MARK ALL THAT APPLY)

- ☐ Prostatitis
- ☐ Impotence
- ☐ Penis Discharge
- ☐ Testicular Pain
- ☐ Infertility
- ☐ Other: _____

Head, Eyes, Ears, Nose, Throat, Mouth
I have the following: (MARK ALL THAT APPLY)

- ☐ Frequent Colds
- ☐ Chronic runny Nose
- ☐ Frequent sore Throat
- ☐ Chronic Cough
- ☐ Allergies
- ☐ Coughing Blood
- ☐ Cough up Mucous
- ☐ Pain on Inhalation
- ☐ Asthma
- ☐ Shortness of Breath on Exertion/at Rest
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Nose Bleeds
- ☐ Painful/red Eyes
- ☐ Poor Vision
- ☐ See Spots/Floaters
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Difficulty Swallowing
- ☐ Frequent Headaches/Migraines

Cardiovascular

I have the following: (MARK ALL THAT APPLY)

- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Cold Hands and Feet
- ☐ Poor Circulation
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Tachycardia (rapid Heart Beat)
- ☐ Heart Valve Disorder
- ☐ Palpitations
- ☐ Other: _____

Skin & Hair

I have the following: (MARK ALL THAT APPLY)

- ☐ Dry Skin
- ☐ Skin Rashes
- ☐ Itching
- ☐ Acne
- ☐ Eczema
- ☐ Hives
- ☐ Psoriasis
- ☐ Hair Loss
- ☐ Premature Graying
- ☐ Brittle Hair
- ☐ Other: _____

Habits

Please indicate usage per day or per week:

Water _____ glasses per day

Coffee _____ cups per day

Soft Drinks _____ per ◯ day ◯ week

Cigarettes _____ per ◯ day ◯ week

Tea _____ cups per ◯ day ◯ week

Alcohol (liquor, beer, wine) _____ glasses per ◯ day ◯ week

Sweets _____ per ◯ day ◯ week

Recreational Drugs _____ per ◯ day ◯ week

Supplements/Herbs/Vitamins/Minerals (please list product name, dosage & reason for taking it):

_____

_____

What do you do for ***exercise***? _____

How often do you exercise per week? _____ times. Please provide details of your Exercise – type and frequency:

_____

Please describe your average daily diet. Try to be specific.

Morning: _____

Lunch: _____

Dinner: _____

Snacks: _____

If there is any other information regarding your present condition that you think would help us, please describe:

_____

_____

Signature: _____ **Date:** _____ (MM/DD/YYYY)

Royal Treatment Therapeutics

#102 – 7777 Royal Oak Avenue, Burnaby BC, V5J 4K2 | office (604) 437 7777 | fax (604) 437 7789 |

RoyalTreatmentTherapeutics.com

royal treatment
THERAPEUTICS

INFORMED CONSENT TO ACUPUNCTURE & TRADITONAL CHINESE MEDICINE (TCM) CARE

While acupuncture treatments and other Traditional Chinese Medicine (TCM) modalities have been proven to be highly effective in correcting a variety of disorders and maintaining overall well-being, Registered Acupuncturists in BC are required to advise patients of the potential risks. Acupuncturists cannot anticipate all the possible risks and complications that may arise with each individual case; however, you should be aware that the following side effects may occur: bruising, minor bleeding, numbness or tingling at or near the needling sites that may last for a few days; light-headedness or dizziness may happen occasionally or even fainting very rarely; burns and scarring are potential risks of Moxibustion; bruising can occur after cupping or Gua Sha scraping treatment. Some symptoms may worsen at the beginning of treatment. If the symptoms worsen and persist for more than 2 days, please inform your Registered Acupuncturist. In very rare instances, spontaneous miscarriage and pneumothorax have been reported.

Statement of Consent

I have read and understood the possible risks of treatment outlined above, but do not expect the Registered Acupuncturist to be able to anticipate and explain all possible risks and complications arising as a result of the treatment.

I understand that my Registered Acupuncturist may review my medical records and lab reports, but all my records will be kept strictly private and confidential and will not be released without my written consent. I also understand that it may be necessary for my Registered Acupuncturist to communicate with other health care professionals regarding my treatment.

I consent to acupuncture treatments, which may include acupuncture needling, Moxibustion, cupping, Gua Sha scraping, reflexology, electro-acupuncture, scalp acupuncture, ear acupuncture, laser acupuncture, point injection therapy, Tui Na massage, and other TCM therapies, by my Registered Acupuncturist. I understand that there are no guarantees regarding cure or improvement of my condition.

Point Injection Therapy involves the use of intramuscular/intradermal injection of vitamins and sterile herbal substances into acupuncture points. I understand that these therapies may be used, upon my consent, to treat my condition. Side effects are rare, but may include allergic reactions, slight pain or stinging sensation at the site of the needle insertion, and bruising. Other rare risks include, but are not limited to: wheezing, rapid heart rhythm and elevated blood pressure. I understand the nature of the proposed procedure and the risks have been explained to me.

I hereby release my **Registered Acupuncturist & Theralase Laser Rehabilitation Therapist Manuela Miutescu** from all liability which may occur in connection with the above mentioned procedures. I understand that I may withdraw my consent and refuse treatment at any time. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

royal treatment
THERAPEUTICS

Cancellation Policy:

In consideration of other patients and my therapist, I understand that a minimum of **48 hours'** notice is required to change or cancel my appointment**. I am aware that it is my responsibility to pay 100% of the treatment fee in the case of late cancellations or missed appointments.** By signing below you understand and agree to our cancellation policy.

Signature: _____ **Date:** _____ (MM/DD/YYYY)

Consent of Treatment:

I confirm the health and medical information given above to be accurate. As well, I understand the therapeutic benefits and possible side-effects of the treatment that may be recommended for my condition and for any future conditions for which I seek treatment, and I consent to the proposed treatment.

_____ _____
Signature of Patient or Legal Guardian Signature of Witness

_____ _____
Printed Name Printed Name

_____ _____
Relationship of Legal Guardian Signed Date

Royal Treatment Therapeutics
#102 – 7777 Royal Oak Avenue, Burnaby BC, V5J 4K2 | office (604) 437 7777 | fax (604) 437 7789 |
RoyalTreatmentTherapeutics.com