Patient Health Record

General Information（个人信息）:

Last name（姓）: _____First name（名）: _____Middle name: _____

Date of Birth（出生日期）: _____Y（年）_____M（月）____D（日）. [◯] M [◯]F

Care Card Number: _____ICBC Claim Number:_____

Health Insurance Company: _____

Policy Number: _____ MemberShip No: _____

Home address（家庭住址）: _____.

City（城市）_____ Province（省）: _____Postal Code（邮编）: _____

Cell Phone（手机）: _____ Landline Phone（固话）:_____

Email Address(电邮): _____

Marital Status（婚姻状况）: _____Occupation（职业）:_____

Date of 1st visit（初诊日期）: _____Y（年） _____M（月） _____ D（日）

Emergency Contact Name（紧急联系人姓名）: _____

Phone Number（电话）: _____ Relationship to Patient（关系)_____

Referral Name/Method (friend, co-worker, family, signage, Internet): _____

Past Medical History & Ongoing Health Condition(既往史和现病史):

Please indicate with a "C" for any of the following that currently apply or a "P" for any that has applied in the past （请指出曾患过的疾病及现在的情况"C"代表现在，"P"代表过去）:

☐Heart Disease心脏病	☐Stomachache胃痛	☐TB结核
☐Stroke中风	☐Abdominal Pain腹痛	☐Hepatitis肝炎
☐Hypertension高血压	☐Nausea/Vomiting恶心呕吐	☐HIV+艾滋病
☐Hypotension低血压	☐Diarrhea腹泻	☐Skin Disease皮肤病
☐High Cholesterol高血脂	☐Constipation便秘	☐Hyperthyroidism甲亢
☐Blood Disease血液病	☐Headache&Migraine头痛	☐Hypothyroidism甲减
☐Asthma哮喘	☐Dizziness眩晕	☐Epilepsy癫痫
☐Rhinitis鼻炎	☐Palpitation心悸	☐Tumor肿瘤
☐Diabetes糖尿病	☐Insomnia失眠	☐Cancer癌症
☐Kidney disease 肾病	☐Fatigue疲劳	☐Neck Pain
☐ Urinary tract infections尿道炎	☐Depression抑郁	☐Low Back Pain
☐Gout痛风	☐Anxiety焦虑	☐Knee or Hip Pain
☐Arthritis关节炎	☐Menstrual Problem月经病	☐Periarthritis of Shoulder
☐Osteoporosis骨质疏松	☐Premenstrual Syndrome经前期综合征	☐Carpal Tunnel
☐Fracture骨折	☐Menopause Syndrome	☐Cervical syndrome
☐Sprain肌肉扭挫伤	☐Infertility不孕	☐Others其它

☐Others其它:_____

Allergies: ☐Food食物_____Medicine药物_____☐Other其它

Family History 家族史:

Gynecology 妇科

Menarche Age （月经初潮年龄）：____Number of Delivery Baby（产育子女数）

Menopause Age（绝经年龄）

Gynecology history（妇科病史）：

Operation/Traumas Record 手术及外伤史

Disease 病名 _____ _____ Y年 _____ M月_____D日

Disease 病名 _____ _____Y年 _____ M月_____D日

Chief Complaints &Present illness主诉和现病史

Please tell us about the specific condition which brought you to our clinic 请告诉我们您来诊的主要原因：

How long have you had this condition 上述症状持续了多长时间？:

How did it start上述症状是怎么开始的？:

What aggravates it 加重因素?

What relieves it 减轻因素?

What are other symptoms accompanied with this condition 伴随其它症状?

What treatment have you had for this condition and how well did it work 做过哪些治疗，效果如何?

Please Notes: Your appointment time has been reserved for you. In courtesy of your therapist & follow patients, we ask that you provide us with 24 hours notices of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated R.TCM.P to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointment at any contact numbers I have provided above. In addition, I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: Date:

Patient Informed Consent to Treatment

R.TCM.P: Yue Fang Wang Reg#:04753

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.
8. Choosing to enter the clinic to receive treatment indicates you understand that despite the health and safety efforts made by Willa Wang TCM & Acupuncture Clinic, it is possible that an exposure to COVID-19 may occur here or anywhere in your daily activities. By pursuing treatment, you accept this risk as your responsibility alone and not that of the clinic, its employees or its practitioners.

Patient Signature: Practitioner Signature:

Date: Date: