K. Sadie Ford - EAST MEETS WEST
H. BSc, R. Ac, R. TCMP, Reflexologist
B13 650 Woodlawn Rd W, Guelph, ON

INFORMED CONSENT REGARDING: ***(Check applicable treatment(s) being performed)***

Reflexology ☐
Acupuncture ☐
Acupressure ☐
Cupping, gua sha, tui na ☐
Other_____ ☐

I understand and accept that the sessions received are of therapeutic value only and fully accept responsibility for the same. I also understand that the practitioner performing this treatment is not a medical doctor, nor is he/she diagnosing, prescribing or replacing my family doctor.

The therapist respects the clients' right to an informed and voluntary consent regarding care and treatment and to obtain consent of the client before providing treatment.

Your comfort and trust in our clinic is very important in providing an optimal client / therapeutic relationship. Treatment will be provided only when there are reasonable expectations that it will be advantageous to the clients' condition.

During treatment tui na (massage), or palpation for the location of acupuncture points may be done to the following areas (Please initial beside each area that you give consent to. In additional oral consent will be sought at the time of treatment).

Pectoral origins and insertions/ Chest Wall _____
Upper and Inner thighs _____
Inguinal groove/Gluteal Crease _____
Gluteal Muscles/SI joint _____

Before, during or after therapy we encourage you to communicate to the therapist about any aspect of the treatment. The therapist respects your right to modify, refuse or terminate treatment, regardless of prior consent given.

This East Meets West clinic respects the confidentiality of all client information unless disclosure is required by law or by order of court. Information will not be released otherwise, unless client's consent is given in writing.

Pertaining to acupuncture treatments; it is very rare, but in some cases a bruise may develop after needling. Cupping and gua sha treatments also leave temporary discolouration of the skin (however, no bruising).

Pertaining to herbal treatments; please pause any prescribed herbal regiment if patient suspects that they may be coming down with a common cold or the flu. Simply contact the clinic and advisement of how to proceed will be given.

I, _____ have read the above and understand my rights to consent to treatment.

_____ _____
Signature Date

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Confidential Patient Health History Form ~ TCM/Reflexology

Personal Information:

Name:_____
Address:_____
City/Province:_____
Postal Code:_____

Occupation:_____
Phone: Home:_____Work:_____
Cell:_____
Email:_____
Sex: Male:___Female:___Other (Please Specify):_____
D.O.B. _____ Age:_____

Physician Information:
Name:_____
Phone:_____

Emergency Contact:
Name:_____
Phone:_____

Referral Information:
Who Referred you?_____

Health Concerns: Please list the concerns you have about your health today….

_____
_____
_____
_____

Family History: Check if your blood relations have had any of the following

☐ Arthritis/Gout	☐ Asthma	☐ Cancer	☐ Chemical Dependency
☐ Diabetes	☐ Heart Disease	☐ High Blood Pressure	☐ Kidney Disease
☐ Stroke	☐ Tuberculosis	☐ Other:_____	☐ Other:_____

Conditions: Please check conditions you currently have with a **C** or have had in the past year with a **P**.

☐ AIDS	☐ Diabetes	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Eczema	☐ Intestinal Disorder	☐ Psychiatric Care
☐ Allergies	☐ Emphysema	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Epilepsy	☐ Liver Disease	☐ Stroke
☐ Anorexia	☐ Fatigue Problem	☐ Lupus	☐ Stomach Disorder
☐ Arthritis	☐ Gallbladder Problem	☐ Measles	☐ Thyroid Disorder
☐ Asthma	☐ German Measles	☐ Menstrual Disorder	☐ Tuberculosis
☐ Bleeding disorder	☐ Glaucoma	☐ Migraines	☐ Ulcers
☐ Bronchitis	☐ Goiter	☐ Miscarriage	☐ Urinary Tract Infection
☐ Bulimia	☐ Gout	☐ Mononucleosis	☐ Vaginal Infection
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Venereal Disease
☐ Cataracts	☐ Hepatitis	☐ Mumps	☐ Other _____
☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Other _____
☐ Chicken Pox	☐ Herpes	☐ Pneumonia	☐ Other _____
☐ Chronic Pain	☐ High blood pressure	☐ Polio	☐ Other _____

Conditions: Please check conditions you currently have with a **C** or have had in the past year with a **P**.

General
- ☐ Fatigue
- ☐ Insomnia
- ☐ Disturbed Sleep
- ☐ Frequent Dreams
- ☐ Excessive Sleep
- ☐ Dislike Cold
- ☐ Dislike Heat
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Alternating Chills and fever
- ☐ Night Sweats
- ☐ Unusual daytime sweating
- ☐ Usually thirsty
- ☐ Seldom thirsty
- ☐ Edema or Swelling
- ☐ Other:_____

Skin
- ☐ Rashes
- ☐ Hives
- ☐ Dry Skin
- ☐ Acne
- ☐ Easily Bruise
- ☐ Changes in lumps or moles
- ☐ Unusual bleeding
- ☐ Other

Head and Neck
- ☐ Headaches
- ☐ Dizziness
- ☐ Jaw Pain
- ☐ Other:_____

Ears and Eyes
- ☐ Failing vision
- ☐ Blurred vision
- ☐ Visual Spots
- ☐ Night Blindness
- ☐ Eye pain/ swelling

Eyes and Ears cont…
- ☐ Ringing in ears
- ☐ Decreased Hearing
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Other:_____

Nose / Throat / Mouth
- ☐ Nose Bleeds
- ☐ Nasal discharge/infection
- ☐ Frequent Sneezing
- ☐ Change in sense of smell
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Change in sense of taste
- ☐ Tooth or gum pain
- ☐ Bleeding Gums
- ☐ Mouth or Tongue Ulcers
- ☐ Other:_____

Muscles and Joints

Pain, Weakness or Numbness in:
- ☐ Neck/shoulder/Arm/Hand
- ☐ Hips/Legs/ Feet
- ☐ Sore low back and knees
- ☐ Muscle Cramps
- ☐ Body Pain
- ☐ Heavy Limbs
- ☐ Swollen Joints
- ☐ Hot joints

Nervous System
- ☐ Fainting
- ☐ Paralysis
- ☐ Tremors
- ☐ Poor Balance
- ☐ Seizures
- ☐ Other:_____

Heart, Lungs and Chest
- ☐ Palpitations

Heart, Lungs and Chest cont..
- ☐ Chest Pain
- ☐ Tightness
- ☐ Rapid Heart Beat
- ☐ Irregular Heart Beat
- ☐ Swelling of the ankles
- ☐ Cough
- ☐ Dry Cough
- ☐ Coughing up phlegm
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma/Wheezing
- ☐ Frequent Colds
- ☐ Pain in rib cage
- ☐ Other: _____

Mental/Emotional
- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Worry
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Frustration or anger
- ☐ Fearfulness
- ☐ Stress
- ☐ Other: _____

Digestive System
- ☐ Nausea
- ☐ Vomiting food
- ☐ Vomiting blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loose Stools
- ☐ Bloody/black stools
- ☐ Stomach Pain
- ☐ Abdominal Pain
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Abdominal bloating/gas
- ☐ Belching

Digestive System cont…

☐ Indigestion
☐ Acid Reflux
☐ Hemorrhoids

Urinary/Genital

☐ Painful urination
☐ Difficult urination
☐ Frequent daytime urination
☐ Frequent nighttime urination
☐ Incontinence
☐ Cloudy Urine
☐ Bloody Urine
☐ Genital pain or itch

Urinary/Genital cont…

☐ Genital discharge or lesions
☐ Painful intercourse
☐ Low sex drive
☐ Excessive sex drive
☐ Other: _____

Male

☐ Impotence
☐ Weak Urinary System
☐ Prostate hypertrophy
☐ Premature ejaculation
☐ Seminal emissions
☐ Other: _____

Female

☐ Irregular Periods
☐ Painful periods
☐ Bleeding between periods
☐ Passing Clots
☐ Scanty Periods
☐ Early Periods
☐ No periods
☐ PMS
☐ Menopausal symptoms
☐ Abnormal PAP smear
☐ Breast lump
☐ Breast pain or discharge
☐ Vaginal discharge
☐ Other _____

Hospitalizations: Please note if you have ever been hospitalized and why

Allergies: List any medication, food, or environmental substances that you are allergic to and reaction you have

Diet: Describe your diet in general terms. Please include in your description how many meals you eat daily, how often you eat out, if you have any dietary restrictions and what your favorite foods are.

Exercise: Do you exercise Regularly? Yes ☐ No ☐
If yes, describe the type of activity you do and how often you do it.

Medication and Supplements: List any medication or supplements you are currently taking.

Medication/Supplement	Dosage	Medication/Supplement	Dosage

Health Habits: Check which substances you use and describe how much

Substance	✓	How much do you use/consume and how often?
Sugar		
Caffeine		
Tobacco		
Alcohol		
Recreational Drugs		
Other		

FOR THOSE WHO MENSTRUATE: Please answer the following questions if they are applicable to you.
Menstrual Cycle: Describe your typical period.

_____
_____
_____

How Many days are there between your periods? Date of last menstrual period: _____
How many days does your period last? _____
Quality of Blood:
□ Light Red □ Bright Red □ Dark Red □ Clotted □ Other: _____

If you are in menopause, please describe the age of onset and past and current symptoms you experience(d).

_____
_____
_____

Pregnancy and Birthing History:
Are you currently Pregnant? □ yes □ no Are you trying to become pregnant? □ yes □ no
If you use birth control, please note what method you use and how long you have been using this method.

_____
_____

Please note the number of pregnancies you have had, the number of deliveries you have had and any relevant information ~ i.e. heavy bleeding with delivery, problem free delivery, c-section etc…

_____
_____
_____
_____

Consent for Treatment:

Patient Signature: _____ Date: _____