Verena McCrae, RAc

_____

First Name: _____ Last Name: _____
Address: _____ City: _____
Zip: _____ Home Phone: _____ Cell Phone:_____
Email: _____ Date of birth: _____
Age: _____ Emergency contact: _____
Relationship: _____ Phone:_____

Do you have a preference for:
- ❑ e-mail 36 hours before appointment
- ❑ text message 24 hours before appoint
- ❑ test message 2 hours before appoint
- ❑ e-mail notification of new and cancelled appointments

Please describe the main reason for your visit today:

_____

Current health care providers:
Family Physician: _____
Phone number: (____)_____
Western Medical diagnosis (if applicable):

_____

Other medical treatment received:
__Fertility Clinic __Physiotherapy __Massage
__Naturopath __Chiropractor __Other:

_____

Please indicate if you have any of the following:
- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ on blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ Hepatitis

Other:_____

List all major childhood and adult illnesses:

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____
_____

*List all medications or supplements, including herbs and vitamins you are currently taking:*_____
_____
_____

Occupation:

_____

Do you have a regular exercise program? Please describe.

_____

Are you on a restricted diet?

_____

How much sugar/dessert do you eat per week?

_____

How much dairy do you eat per week?

_____

How much coffee or tea do you drink per week?

_____

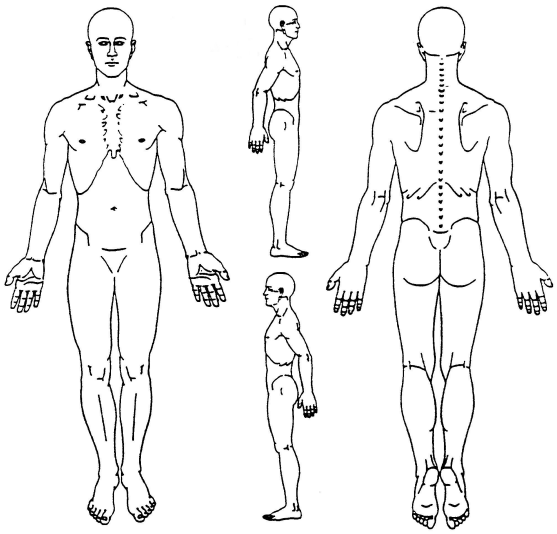
How much alcohol do you drink per week?

_____

Do you do any drugs? How much per week?

_____

Indicate painful or distressed areas.
Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).



Sensations/pain characteristics (check all that apply):
___Sharp ___Burning ___Moving ___Tingling
___Dull ___Severe ___Stabbing ___Shooting
___Throbbing ___Numbness

What relieves the pain (ice, rest, activity, massage, heat...)?

_____

What aggravates the pain (weather, heat, cold, rest, activity...)?

_____

WOMEN'S HEALTH:

Are you pregnant now?
□ Yes □ No

Number of children: _____

Number of pregnancies: _____

Age of first period: _____

Age of menopause if applicable: _____

Is your menses cycle regular?
□ Yes □ No

Average number of days in flow: _____

The flow is:
□ Normal
□ Heavy
□ Light

The color is:
□ Red
□ Dark
□ Purple
□ Light brown
□ Brown

Do you have any of the following menstruation related symptoms?
□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

Current Birth control:_____

MEN'S HEALTH:

□ Discharge
□ Pain or swelling of testicles
□ Ejaculatory problems
□ Impotence/erectile dysfunction

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan/Liver
___ Irritability/frustration/impatient
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision/poor night vision
___ Red / Dry / Itchy eyes
___ Headaches / Migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___PMS
___ Genital itching / pain / rashes

Xin/Heart
___ Palpitations
___ Chest pain/tightness
___ Insomnia/Sleep problems
___ Restless/easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue/mouth ulcers/cankers

Shen/Kidneys
___ Frequent urination
___ Bladder infection
___ Lack of Bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei/Lungs
___ Dry cough
___ Cough with Phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system

Pi/Spleen
___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased Thirst
___ Prefer Warm / Cold drinks
___ Sweat easily
___ Alternate fever / chills

Signature and Date Signed:_____

Verena McCrae, RAc

Treatment Consent Form

Safety and Policies

The purpose of Acupuncture and Chinese Medicine is to restore and maintain balance to the body and its energetic systems (nerves, organs, hormones, brain and spirit).

Holistic Medicine treats the body, not the disease; therefore much emphasis is put on lifestyle and your own responsibility for maintaining appropriate balance in your life. The goal of the practitioner is to guide your body into better functioning to enable the body to heal itself.

Here are a few things to keep in mind:
1) *mild bruising or slight local pain* at an occasional needle sight, or at a pressure point where deep massage/cupping/guasha techniques have been employed;
2) *aggravation of symptoms*, usually temporarily, in order to catalyze the transition into healing (*known as the Healing Crisis)*
3) *a slight feeling of faintness,* especially if receiving a treatment in the upright position (primarily on the first treatment), blood sugar levels are low at the time of treatment, and/or if there is apprehension or fear concerning the treatment *(please share any concerns with practitioner, we'd be glad to help ease your concerns you may have);*
4) *unexpected emotions or feelings* may present themselves during treatment as this may well be a part of the healing process;
5) *and a feeling of wooziness and/or drowsiness,* especially during the first few treatments, and also when electrical stimulation is used.

**The last effect is likely due to brain's secretion of endorphins an other neurohormones (that act as the body's natural opiates or painkillers) in response to treatment. Consequently, patients are advised not to operate a motor vehicle immediately following acupuncture, especially on the first visit. Inversely, patients often report feelings of well-being and extreme relaxation, likely due to the same release of endorphins and other neurohormones.

Without exception, *only sterilized disposable (single use) needles* are used at this clinic.

Rare but serious complications associated with acupuncture have been reported in literature.
Considering the rareness of any of the above complications, acupuncture is extremely safe.

1) Joint infections can occur by needling specific points that are intra-articular (entering into a joint) if bacteria are present on the skin at the time of needle insertion *(alcohol swabbing will prevent presence of any bacteria)*. Such a condition requires the administration of intravenous antibiotics.
2) Nerve damage is possible as some acupuncture points are situated over nerves. Complications, if any, usually amount to experiencing numbness for several hours following treatment.
3) Pneumothorax (collapse of the Lung) can occur if any acupuncture needle is inserted too deeply into the upper back, the clavicular area at the apex of the Lung, or intercostal (between the ribs) areas. If pneumothorax does occur, emergency medical intervention is necessary, but a full recovery usually ensues.
4) A needle may break while in the body, and surgical removal may be necessary to extract it.
Again – these are rare occurrences; complications such as the above just need to be shared with you for awareness.

Please be aware that 24 hours notice is required for cancellations or changes to appointments so that your time can be made available for another client. Same day cancellations are subject to a fee of 40 dollars.
I have read the above information and understand the content. I hereby give consent to have treatment performed on me by any of the professional practitioners of this clinic.

Signature of Patient and Date Signed

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