Acupressure and Tai Chi Therapy Intake

Dr Yu Ming Ye

Confidential Patient Information

First Name:________________________________ Last Name:______________________________________

Date of Birth (DD/MM/YYYY)__________________ Age:_____________

Address: _________________________________ City: ____________Province: ______ Postal Code:__________

Phone (home):___________________work:_____________________ cell:________________________________

Marital Status:_____________ Occupation:________________________ Employer:__________________________

Height:______________________________________ Weight:____

How did you hear about the clinic (or who)?____

Have you ever received Acupressure or Tai Chi Therapy?____

If so, when/who ________________________________

Reason for Visit

What is your major current complaint(s)? ____

When did this start/how long? ____

Have you had similar condition on the past? If Yes, When?____

Are you experiencing any numbness or tingling? If Yes, Where?____

What activities aggravate your complaint? ____

Other Doctors/ Therapists seen for this condition?____

Have you had x-rays taken? ____

Is this condition a result of a motor vehicle or work related accident? _____________________________________

Current Medical Information

(Please check if you have now or had in the past)

Headaches	Pins & Needles in legs	Fainting
Neck pain	Pins & Needles in arms	Loss of smell
Sleeping Problems	Numbness in fingers	Loss of taste
Back pain	Numbness in toes	Diarrhea
Nervousness	Shortness of breath	Cold feet
Tension	Fatigue	Cold Hands
Irritability	Depression	Stomach upset
Chest pain	Lights bother eyes	Constipation
Dizziness	Loss of memory	Cold sweats
Face flushed	Ringing in the ears	Loss of balance

Family Physician Name and address: ____

May we contact your physician? Yes ☐ No ☐ Last Physical Exam Date:______________________

Current medications:____

Past Serious Injuries:____

Past Surgeries/Hospitalizations: ____

Sport injuries? Traumas? Fractures? Sprains? ____

Allergies/Sensitivities? ____

Number of Pregnancies (if applicable)? ____

Do you Exercise? (What type?)____

Do you smoke? _____________________________ Drink Alcohol?_______________________________________

Age of Mattress?____

Sleeping posture (side/stomach/back):____

Do you currently have custom foot orthotics? ____

Family History

	Father's Side	Mother's Side
Heart Disease	Yes ☐	Yes ☐
Arthritis	Yes ☐	Yes ☐
Cancer	Yes ☐	Yes ☐
Diabetes	Yes ☐	Yes ☐
Stroke	Yes ☐	Yes ☐
High Blood Pressure	Yes ☐	Yes ☐
Other	Yes ☐	Yes ☐

Accident Information (if Applicable)

Have you been an accident recently? (within the last year) Yes ☐ No ☐

Work ☐ Auto ☐ Other ☐ Date ______________ Nature of Accident ____________________________________

Did you experience any symptoms after the accident? What? ____

Did you feel popping or tearing noise in back of your neck? Explain ______________________________________

Did you require post-accident hospitalization? ____

Where? ____________________________ When? __________________ X-rays Taken? ______________________

Have you lost days at work? ___________________________ Dates ____

Is insurance involved?______ Which company, address:____

____

Attorney's name, if any________________________ Claim #____

Comments (Office use only)____

____

Have you been in an accident(s) in the past ? (over 1 year ago) Yes ☐ No ☐

Work ☐ Auto ☐ Other ☐ Date________________________

Details of the accidents(s) / Date(s) ____

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Consent to Acupressure & Tai Chi Therapy

Dr. Yu Ming Ye

Name____ (print please) Date_________________

I hereby request and consent to the performance of **Acupressure and Tai Chi Therapy** and other procedures related to acupressure, as necessary, including *acupressure stimulator, acupressure aids, meridian trace with herbal oil and chi points pressure with warm herbal stones, as well as healing Tai Chi* by the above named doctor / therapist or another duly authorized doctor/therapist in the clinic.

Potential risks and side-effects including but not limited to: temporary flare up of condition, residual post-treatment soreness have been explained to me.

I do not expect the doctor / therapist to be able to anticipate and explain all possible risks and complications.
I wish to rely on the doctor / therapist to exercise judgment during the course of the treatment which the doctor / therapist feels at the time, based upon the facts then known, is in my best interests.
I understand that the results are not guaranteed.

I have read this consent form.
I have also had an opportunity to **ask questions** about its content, and by signing below I agree to the above mentioned Acupressure and Tai Chi Therapy procedures.
I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.
I acknowledge that it is my responsibility to inform the doctor / therapist immediately, and at any time during a treatment session, if I am not comfortable with what they are doing.
I also acknowledge that I can withdraw my consent at any time.

Thank you for taking time to read and to sign this form.

Signature: ____

Guardian name (if applicable): ________________________________

Guardian Signature: ____

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