Family Tree
acupuncture and herbal medicine

17 Ranelagh Drive,
Mount Eliza, 3930
Phone: 97878288

Family Tree Acupuncture and Herbal Medicine

# Womans Health Form

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Today' s Date: | Appointment Date: | | |
| First name: | Last Name: | Title: | Relationship status: |
| Date of Birth? | Age: | Sex: | |
| Address | Street: | Suburb: | Postcode: |

| | | | |
|---|---|---|---|
| Please supply email for appointments or invoices to be sent to you. | Mobile: | Phone (H): | Phone (W): |
| Name of Doctor: | Doctor phone no.: | Doctors Address: | |

## EMERGENCY CONTACT

| | | | |
|---|---|---|---|
| Emergency Contact: | Relationship to Patient: | Mobile: | Phone (W): |

## HOW DID YOU HEAR ABOUT WELL WOMAN?

How did you hear about Family Tree Acupuncture?

Please leave the name of the person who referred you so we can thank them!

☐ Tick if you have had TCM Acupuncture in the past?

☐ Tick if you have had Chinese Herbs before?

## GENERAL INFORMATION

| | | |
|---|---|---|
| Occupation:<br><br>Duties (If relevant to your condition): | Would you like to be on our mailing list for events and free health workshops:<br><br>☐ Yes ☐ No | Pension, health care or veteran's affairs card?<br>Card Number:<br>Expiry Date: |

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## REASON FOR VISIT?

**How can we help you today?**

**How long have you had this/these condition (s). When did you first notice it/them?**

**Prior Treatment(s) for this condition? If so, what treatment and did it help?**

**What Makes your condition better? What makes it worse?**

## GENERAL HEALTH

What (if any) exercise do you do?

If you smoke, how many cigarettes do you smoke a day?

How much tea, coffee, energy drinks do you drink per week?

Have you ever taken or presently take any drugs of addiction? If so, what?

How much alcohol do you drink per week?

## MEDICAL HISTORY

What (if any) MEDICATIONS or supplements are you on?

Do you have any Allergies to any medications? ☐ Yes ☐ No

If Yes what medication are you allergic to and what reaction do you have?

Do you have any Allergies to tape/ foods/ Contact dermatitis? ☐ Yes ☐ No

If Ye, which foods are you allergic to and what reaction do you have?

Do you have any children? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If Yes, how many weeks pregnant are you (at time of appointment)?

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## HEALTH CHECKLIST

Please indicate with PAST, CURRENT or FAMILY medical History ONLY if any of the conditions below apply

| | | | |
|---|---|---|---|
| Heart Condition ☐ yes ☐ Current ☐ Family | Stroke ☐ Past ☐ Current ☐ Family | High Blood Pressure ☐ Past ☐ Current ☐ Family | Low Blood Pressure ☐ Past ☐ Current ☐ Family |
| Diabetes ☐ Past ☐ Current ☐ Family | Deep Vein Thrombosis ☐ Past ☐ Current ☐ Family | Neurological Conditions ☐ Past ☐ Current ☐ Family | Epilepsy ☐ Past ☐ Current ☐ Family |
| Respiratory Condition ☐ Past ☐ Current ☐ Family | Kidney Disorder ☐ Past ☐ Current ☐ Family | Cancer ☐ Past ☐ Current ☐ Family | Lung Conditions ☐ Past ☐ Current ☐ Family |
| HIV/AIDS ☐ Past ☐ Current ☐ Family | Sprain/Strain/Fracture ☐ Past ☐ Current ☐ Family | Osteoporosis ☐ Past ☐ Current ☐ Family | Headaches/Migraines ☐ Past ☐ Current ☐ Family |
| Hepatitiis ☐ Past ☐ Current ☐ Family | Arthritis ☐ Past ☐ Current ☐ Family | Dizziness/Fainting ☐ Past ☐ Current ☐ Family | Contagious Illness ☐ Past ☐ Current ☐ Family |
| Skin Condition ☐ Past ☐ Current ☐ Family | Digestive Problems ☐ Past ☐ Current ☐ Family | Spinal or Head Injury ☐ Yes ☐ No | Wear a pacemaker ☐ Yes ☐ No |
| Recent weight ☐ Gain ☐ Loss | Haemophiliac ☐ Yes ☐ No | Possibility of Pregnancy ☐ Yes ☐ No | Upcoming Surgeries ☐ Yes ☐ No |
| Anxiety ☐ Past ☐ Current ☐ Family | Depression ☐ Past ☐ Current ☐ Family | Other: | |

## PAIN OR TENSION

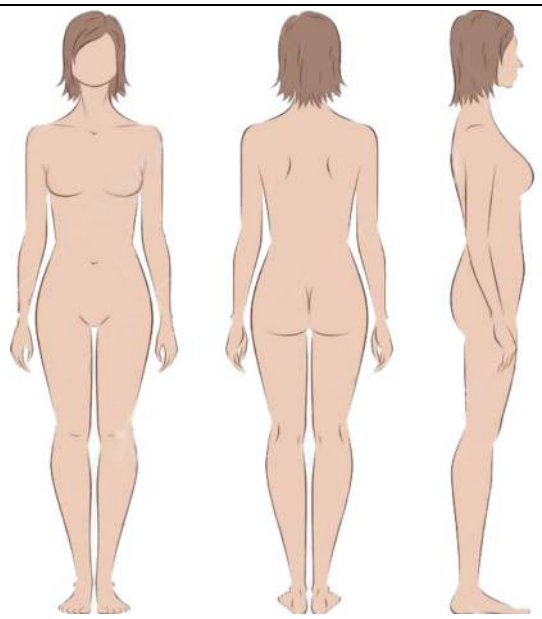

**Diagram: Office use**

**Sensations/pain characteristics**

| | |
|---|---|
| ☐ Dull | ☐ Sharp |
| ☐ Severe | ☐ Burning |
| ☐ Stabbing | ☐ Moving |
| ☐ Shooting | ☐ Tingling |
| ☐ Throbbing | ☐ Numbness |

## JUST A FEW QUESTIONS

On a scale of 1-10, how would you rate your Pain level? ( 10 being most painful)?

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

Do you experience urinary frequency, urgency, burning, dribbling, or retention? ☐ Yes ☐ No

History of urinary tract infections? ☐ Yes ☐ No

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| | |
|---|---|
| Are your bowel movements regular? ☐ Yes ☐ No<br>How many times per day/week?<br>Are they formed? ☐ Yes ☐ No<br>Are they Loose? ☐ Yes ☐ No<br>Do you get Constipated? ☐ Yes ☐ No<br>Alternate from loose to difficult to pass ☐ Yes ☐ No | Please describe in general what you eat?<br><br>Cravings? (sweet, spicy, salty, dairy, wheat, veggie, etc.) ? |
| Do you have trouble falling asleep? ☐ Yes ☐ No<br>Are you a light sleeper? ☐ Yes ☐ No<br>How many hours per night?<br>Do you have vivid dreams? ☐ Yes ☐ No<br>Wake & difficult falling back to sleep? ☐ Yes ☐ No | Please tick which describes you from an emotional standpoint (MOSTLY)<br>☐ Calm ☐ Happy ☐ Excitable<br>☐ Irritable ☐ Worrier ☐ Overthinking<br>☐ Anxious ☐ Sad/Grieving ☐ Impatient<br>☐ Stressed ☐ Overwhelmed ☐ Exhausted<br>☐ Frightened ☐ Other: |

**PLEASE TICK EACH SYMPTOM BELOW THAT YOU CURRENTLY HAVE. LEAVE BLANK IF N/A**

**Gan (LR)**

- ☐ Emotional Eating
- ☐ Visual Problems/floaters
- ☐ Blurred/Poor Night
- ☐ Red/Itchy Eyes
- ☐ Headaches/Migraines
- ☐ Dizzyness
- ☐ Feeling of lump in
- ☐ Muscle twitching / spasm
- ☐ Neck / shoulder tension
- ☐ Brittle nails
- ☐ Deep Sighing
- ☐ Sensation/pain under rib cage
- ☐ Genital itching / pain / lesions

**Xin (HT)**

- ☐ Palpitations
- ☐ Chest Pain/Tightness
- ☐ Restless/Easliy Agitated
- ☐ Forgetful
- ☐ Bitter taste in mouth
- ☐ Aversion to Heat
- ☐ Tongue/mouth ulcers/cankers

**Shen (KI)**

- ☐ Wake to Urinate
- ☐ Fell Cold Easily
- ☐ Cold hands & Feet
- ☐ Night sweats/ Hot Flushes
- ☐ Spontaneous sweating without exertion
- ☐ Low Sex Drive
- ☐ High Sex Drive
- ☐ Loss of Head Hair
- ☐ Hearing Problems
- ☐ Tinnitus (ringing in
- ☐ Poor long term memory
- ☐ Ankle swelling

**Fei (LU)**

- ☐ Dry Cough
- ☐ Cough with phlegm
- ☐ Nasal Discharge/Drip
- ☐ Sinus infection/Congestion
- ☐ Itchy / painful throat
- ☐ Skin rashes / hives
- ☐ Shortness of breath
- ☐ Allergies / asthma
- ☐ Weak immune system

**Pi (SP)**

- ☐ Heaviness in the head/ body
- ☐ Fatigue / after eating
- ☐ Difficult getting up in
- ☐ Water retention
- ☐ Muscular tiredness / weakness
- ☐ Lower Back Pain
- ☐ Painful or weak knees
- ☐ Bruise easily
- ☐ Unusual bleeding
- ☐ Poor appetite
- ☐ Increased appetite
- ☐ Poor digestion
- ☐ Nausea / vomiting
- ☐ Bloating / gas
- ☐ Haemorrhoids
- ☐ Abdominal pain
- ☐ Overweight
- ☐ Foggy mind
- ☐ Yeast infection
- ☐ Increased Thirst but no desire to drink
- ☐ Prefer Warm drinks
- ☐ Prefer Cold drinks

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## GYNAECOLOGICAL HEALTH CHECKLIST

**Have you had any of the below procedures or conditions?**

- ☐ Abnormal pap smear?
- ☐ Unique shaped uterus (heart shape
- ☐ Polyps
- ☐ Cervical biopsy and/ or cauterization?
- ☐ STD's (Chlamydia, PID etc)
- ☐ Pelvic Adhesions
- ☐ Dilation and Curette ( D&C)
- ☐ Recurrent bladder infections (UTI's)?
- ☐ Prolapsed Uterus
- ☐ Recurrent yeast/thrush infections
- ☐ Uterine Fibroids
- ☐ Pelvic Abnormalities
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Endometriosis
- ☐ Damaged/blocked fallopian tubes

## PREVIOUS OBSTETRIC HISTORY

| **Year / Month** eg.. 2012/05 | **Type of labour & Birth** Normal / Induced/ assisted forceps/ ventouse/ caesarean | **Length of Labour** 18 hours | **Pregnancy Complications** Gest diabetes, placenta praevia, breech etc | **Outcome** Live Boy/Girl | **Postnatal Status** Breastfeeding, PPH P/N Depression |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## PRESENT AND PAST MENSTRUAL CYCLE

Is/Was your menstrual cycle Regular/Irregular

Date 1st day of last menstrual cycle

How old were you when you first menstruated?

How many Days do/did you bleed?

Menstrual cycle length ( ie 26-30 days)

Describe your flow

What colour is/was the blood?

If blood has clots, when in cycle

Do/Did you experience Period Pain? Yes No

What relieves pain?

Pre- menstrual Symptoms (tick applicable)

☐ Nausea ☐ Headache ☐ Bloating ☐ Cramps ☐ Fatigue ☐ Acne ☐ Night sweats ☐ Change in ☐ Moodiness ☐ Breast tenderness ☐ Sleep disturbances

If you have vaginal discharge Please describe colour, consistency and odour?

Have you taken the Oral Contraceptive Pill ☐ Yes ☐ No

If yes or presently, for how long?

If in past, When did you stop?

Have you ever had an IUD? ☐ Yes ☐ No

Have you ever had Depo-Provera? ☐ Yes ☐ No

Have you been exposed to chemotherapy or radiation? ☐ Yes ☐ No

Do you have excessive facial or body hair? ☐ Yes ☐ No

Date of last Pap smear:

Peri Menopausal/ Menopausal Symptoms

☐ Hot Flush ☐ palpitations ☐ Night sweating ☐ Mood Swings ☐ Weight gain ☐ Spontaneous sweating ☐ Irritability

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## PATIENT INFORMATION AND CONSENT FORM

***Please read this information carefully, and ask your practitioner if there is anything that you do not understand.***

Whilst acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effect can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

**What are the possible side effects of acupuncture?**

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

**What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?**

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

**Is there anything your practitioner needs to know?**

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

**Statement of Consent**

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

**Privacy Policy**

The information received and collected about our clients/patients from their visit to Family Tree Acupuncture is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Family Tree, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Family Tree.

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I am assured by Family Tree that any questions I may have about my proposed care will be fully and honestly answered to the best of her ability. I agree to rely upon her judgment, based on her knowledge of the facts of my condition at any time, to use the treatment most suited to my condition.

I understand this consent form will cover the entire course of my treatment for current and any future condition(s) for which I seek treatment from her. I understand my consent may be withdrawn by me at any time. I agree to my Acupuncturist communicating and seeking any information deemed necessary from my medical doctor.

☐ YES, I Agree & Give Consent to Treatment

Signed (at your first appointment) _____ Date:

*Please read the following agreements carefully*

## APPOINTMENT POLICY

Welcome to Family Tree Acupuncture. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Clients are pleased to find out that we are usually on time and honor us with being punctual themselves. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, please understand that we will do our best to accommodate your needs in the appointment time allocated to you and as a consequence your treatment time will be reduced to maintain time schedule for the next patient. A full fee will be expected for the service.

Family Tree Acupuncture understands that on rare occasions emergencies can happen, requiring you to cancel or reschedule your appointment. We are pleased to try and accommodate your needs in these circumstances.

Appointments cancelled or rescheduled with ***less than 24 hours notice*** will result in a charge of ***25% of full scheduled service fee*** being invoiced to you.

If you miss an appointment, ***No call, No show,*** a charge of ***100% of full scheduled service fee*** will be invoiced to you.

Thank you for your understanding.

***Any questions regarding my appointments have been addressed. I have read this statement and fully understand it.***

☐ YES, I Agree to Appointment & Cancellation Policy

Signed (at your first appointment) _____ Date: _____