Nourishlife Traditional Chinese Medicine with Dr Tia Bhana-Williams.

Newport Specialised Therapies 423 Melbourne Rd Newport Ph: 0439 841 413

Name:

Address:

Phone numbers: Home: Mob:

Email:

 Occupation:

Reason for Visit:

Family Physician name: Family Physician phone:

Western Medical diagnosis (if applicable)

Other medical treatment received (circle)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fertility clinic | Physiotherapy | Massage | Naturopathy | Chiropractic | Other: |

Please indicate with a ‘P’ (past) ‘C’ (current) ‘F’ (family) if any of the conditions below apply:

|  |
| --- |
| Heart conditions : Stroke: High blood pressure: Low blood pressure: |
| Diabetes: Deep vein thrombosis: Neurological, Spinal, or head injury: |
| Respiratory condition: Kidney disorder : Cancer Hepatitis |
| HIV / AIDS: Sprain/Strain/Fracture: Osteoporosis : Headaches/migraines |
| Jaw pain: Arthritis: Dizziness: Fainting : Contagious illness  |
| Skin condition: Digestive problems : Haemophiliac : Wear a pacemaker |
| Lung condition: Epilepsy: Possibility of Pregnancy : Upcoming Surgeries |

Please list herbal medicine and other supplements currently taking:

1. 2.

3. 4.

5. 6.

Please list any allergies (food, drugs, environmental, etc.):

1. 2.

3. 4.

Have you been hospitalised and/or treated for any infectious/serious conditions or surgeries

Please explain when:

What it was:

On the figures below, please circle the areas of concern/pain;



Sensations/pain characteristics (check):

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…)

Do you use the following? If so how often? Cigarettes: \_\_\_\_\_\_\_\_ Alcohol: \_\_\_\_\_\_\_\_ Drugs: \_\_\_\_\_\_\_\_ Coffee: \_\_\_\_\_\_\_ Soft Drinks: \_\_\_\_\_\_\_

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

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Gan** Irritability |  | Sighing |  | Wake to urinate |  | Allergies / asthma |  | Water retention |  |
| Fatigue / after eating |  | Brittle nails  |  | Feel cold easily |  |  Grief / sadness |  | Nausea / vomiting |  |
| Frustration |  | Sensation or pain under rib cage |  | Cold hands / feet |  | Skin rashes / hives |  | Bloating / gas |  |
| Depression |  |  PMS |  | Night sweats hot flushing |  | Dry mouth / throat / nose |  |  Haemorrhoids |  |
| Stress |  | shoulder tension |  | Low sex drive |  | Itchy / painful throat |  | Alternate constipation / loose |  |
| Emotional eating |  | **Xin**Palpitations |  | High sex drive |  | Sinus infection / congestion |  | Foggy mind |  |
| Unfulfilled desires |  | Chest pain / tightness |  | Loss of head hair |  | Nasal discharge / drip |  | Yeast infection |  |
| Visual problems |  | Insomnia Sleep problems |  | Hearing problems |  | **Pi**Constipation Loose stool |  | Overweight |  |
| Floaters |  | Restless / easily agitated |  | Crave salty food |  | Heaviness in the head / body |  | Aversion to cold |  |
| Blurred vision |  | Vivid dreams |  | Fear |  | Difficulty getting up in morning |  | Prefer Warm / Cold drinks  |  |
| poor night vision |  | Lack of joy in life |  | Poor long term memory |  | Musculartired / weak |  | Increased Thirst |  |
| Red / Dry / Itchy eyes |  | Forgetful |  | Ankle swelling |  | Bruise easily |  | Pensive / over-thinking |  |
| Headaches / Migraines |  | Aversion to heat |  | **Fei** Dry cough |  | Unusual bleeding (stool, nose, etc) |  | Sweats easily |  |
| Dizziness |  | Bitter taste in mouth |  | Cough with Phlegm |  | Bad breath |  | Heartburn |  |
| Feeling of lump in throat |  | Tongue / mouth ulcers / cankers |  | Alternate fever / chills |  | Increased appetite |  | Abdominal pain |  |
| Muscle twitching / spasm |  | **Shen** Frequent urination |  | Weak immune system |  | Poor appetite |  | Intestinal pain |  |
| Genital itching / pain / rashes |  | Bladder infection |  | Shortness of breath |  | Crave sweets |  |  |  |
| Bitter taste |  | Lack of Bladder control |  | Tinnitus |  | Poor digestion |  |  |  |

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

What is your occupation?

Do you enjoy your work?

How many hours per week do you work?

 Is it stressful?

 What areyour duties?

Are your bowel movements regular? How many times per day/week?

Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention?

What colour/shade of yellow is it?

Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken Antibiotics?

 How many times have you taken oral steroids?

Please describe in general what you eat in a typical day

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you crave any flavour above all else? Sweet, sour, salty ect

Do you have trouble falling asleep?

Are you a light sleeper?

How many hours per night?

 Do you have vivid dreams? If so, what are they about?

Do you wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say?

Steady, moody, depressed

**YOUR MENSTRUAL CYCLE:**

 Date last menses began

Is your menstrual cycle: Regular \_\_\_ Irregular \_\_\_

How many days do you bleed in total /

How old were you when you had your first menstruation?

Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy \_\_\_ Light \_\_\_ Average \_\_\_

Consistency of blood: Watery \_\_\_ Thick \_\_\_ Average \_\_\_

Does your blood contain clots? Yes \_\_\_ No \_\_\_ …and...

At which point during the cycle? Start \_\_\_ Mid \_\_\_ End \_\_\_Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes \_\_\_ No \_\_\_

When? Before, \_\_\_ During \_\_\_\_\_\_\_\_\_\_\_\_\_ (please specify which days) After \_\_\_

What describes the pain? Stabbing \_\_\_ Cramping \_\_\_ Dull \_\_\_ Heavy \_\_\_ On/off \_\_\_

Do you experience Pre-menstrual symptoms (PMS)? \_\_\_\_\_\_\_\_\_Please check all that apply.

Breast tenderness \_\_\_ Cramps \_\_\_ Acne \_\_\_ Change in Bowel \_\_\_ Bloating \_\_\_ Headaches \_\_\_ Nausea \_\_\_ Moodiness \_\_\_Fatigue \_\_\_ Night sweats \_\_\_ Sleep disturbances \_\_\_

Please list any other pre-menstrual symptoms:

Do you ovulate on your own? Yes \_\_\_ No \_\_\_ What Day? \_\_\_\_\_\_

Do you chart your cycle?

(Circle) BBT / Ovulation sticks / Saliva

Do you experience pain around ovulation? Yes \_\_\_ No \_\_\_

 Do your breasts get tender around ovulation? Yes \_\_\_ No \_\_\_

Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes \_\_\_ No \_\_\_

How many times have you been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you given birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ages of children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex of Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given names

Have you had any miscarriages?

If yes, how many, at how many weeks pregnant, and in what year(s)?

How many times have you had a D&C preformed? \_\_\_\_\_\_\_\_\_\_\_\_

How many abortions have you had? \_\_\_\_\_\_\_\_\_\_\_\_ In what year(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any problems that occurred during these pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with:

STD? ……….Pelvic inflammatory disease? ………Uterine fibroids? ………

Polyps? ……………Pelvic adhesions? …………Prolapsed uterus? …………………

Unique shape of uterus? ............... Endometriosis? …………… PCOS (polycystic ovariansyndrome)?

Date of last pap smear: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/yyyy)

Have you ever had an abnormal pap smear? Yes \_\_\_ No \_\_\_

Have you ever had a cervical biopsy or operation? Yes \_\_\_ No \_\_\_

Do you get yeast infections regularly? Yes \_\_\_ No \_\_\_

Do you get bladder infections regularly? Yes \_\_\_ No \_\_\_

If answered yes, list STD’s:

Do you experience vaginal discharge? Yes \_\_\_ No \_\_\_

If yes, what colour? White \_\_\_ Yellow \_\_\_ Green \_\_\_ Pinkish \_\_\_ Red \_\_\_

If yes, what consistency? Watery / thin \_\_\_ Thick \_\_\_ Sticky \_\_\_

If yes, does it have foul odour? Yes \_\_\_ No \_\_\_

Have you taken oral contraceptives? Yes \_\_\_ No \_\_\_If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever had an IUD? Yes \_\_\_ No \_\_\_

Have you ever taken Depo-Provera? Yes \_\_\_ No \_\_\_

**Please print, complete, and fax in forms before your initial appointment.**

**Thank you**

**Nourishlife Chinese Medicine**

**423 Melbourne Rd Newport**

**0439 841 413**

Patient Information and Consent Form

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

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well­being, 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 effects 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 1­2 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 anti­coagulants (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 Nourishlife is strictly private and confidential.  It is used and viewed only by the healthcare professionals and staff employed by Nourishlife, 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 nourishlife

We will not give, share, sell, or transfer any personal information to a third party (unless required to by law).  Under absolutely no circumstances would this communication happen without the signed consent of the client/patient.  The client/patient information will be stored both in digital and hard copy format on Nourishlife premises.

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Print name in full

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date