

helping you help yourself

Active Life Health Clinic

Dr. Melissa Carr, B.Sc., Dr.TCM, R.Ac. • 410-2184 West Broadway, Vancouver, BC • 604-783-2846

🌻 please print as legibly as possible. Thank you!

Today's Date: ___ day ___ / ___ month ___ / ___ year ___ Birth date: ___ day / ___ mo / ___ yr

Name: Dr/Mr/Mrs/Ms _____

Address: _____ City _____ Postal code _____

Tel: home _____ work/mobile (circle) _____ Email: _____

Contact preference for reminders: ___ home tel. ___ work/mobile tel. ___ email

Can I contact you periodically for check ups? ___ yes ___ no

Occupation: _____

How did you learn about Dr.Carr? _____

PERSONAL MEDICAL HISTORY

Reason for today's visit: _____

Have you ever been treated with Traditional Chinese Medicine? ___ yes ___ no

Other current therapies _____

Who is your physician? _____ Telephone: _____

Surgeries: _____

Please list any pharmaceuticals you are currently taking _____

Please list any supplements you are currently taking _____

Are you pregnant? ___ yes ___ no Do you have any allergies? _____

Please check any of the following that are significant to your medical history:

- | | | | | |
|-------------------------------------|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> TB | <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin conditions | |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Venereal disease | |

Lifestyle (please check those that apply and give frequency):

Alcohol _____ Tobacco _____ Drugs _____

Exercise type and frequency: _____

Are you interested in learning about an exercise program? ___ yes ___ no

Diet: ___ Vegetarian ___ Vegan ___ Coffee ___ Tea

Gynecology:

Age of first menses: _____ Length of cycle: _____ Menses duration: _____

Age of menopause: _____

Are you currently taking the birth control pill? ___ yes ___ no

___ Number of pregnancies ___ Irregular period ___ Painful periods ___ PMS ___ Breast lumps

EMERGENCY CONTACT:

Name: _____ Telephone: _____

(Patient signature)

(Date)

General Information/Consent Form for Patients

Information

1. Please be assured that all patient/practitioner relationships are kept in the strictest of confidence.
2. A first time consultation fee for traditional Chinese medicine and acupuncture of \$95 will apply. The first consultation takes 1 hour.
3. Acupuncture sessions, approximately 1 hour per session, include the consultation and the fee is \$75. A package of six sessions can be pre-paid for \$375 (this reduces the per-session cost to \$62.50).
4. Facial microcurrent rejuvenation sessions last 45 minutes to 1 hour per session and the fee is \$135. A package of ten sessions with supplements and after-care products can be pre-paid for \$1300. Photographs will be taken before and throughout the duration of your treatment for monitoring progress to be kept in your file. This is an important gauge of the changes you experience with the procedure. In combination with acupuncture, these sessions may be covered by your extended Health Plan.
5. Body or face cupping sessions alone last for half an hour with a fee of \$75. A package of 6 sessions of body cupping (1/2 hour each session) can be pre-paid for \$375. NOTE: Cupping sessions *alone* will likely not be covered by private medical insurance.
6. Herbal formulas vary in cost, depending on the prescription and will cost \$10 to \$30 per week.
7. Please note it is required that tax (GST) be applied to all services and products.
8. Please note that a charge of \$40 will be imposed on NSF cheques.
9. At least 24 hours notice is required for cancellations, or the full session charge will be implemented.
10. Please note that if you are more than 15 minutes late, treatment may not be given, although full charge will be implemented. This is because it can disrupt the treatments of subsequent patients.
11. Please ensure that you have eaten within 3 hours prior to acupuncture treatment.
12. Acupuncture treatment may be refused if:
 - 1) patient has consumed alcohol or recreational drugs within 24 hours of treatment.
 - 2) at the discretion of the practitioner.
13. Please do not brush your tongue the day of the consultation, as observation of the tongue is important for a Traditional Chinese Medicine diagnosis.

Preventing illness is always preferable to treating illness, so when we have achieved our goals, I suggest we maintain visits every few months or every season.

Our first visit together will be an hour long and is a complete consultation. We will discuss your health history and chief complaints. I will then diagnose you according to Traditional Chinese Medicine principles and create a personalized treatment plan.

Acupuncture heals from the outside in and traditional herbs treat you from the inside out...together they make a powerful therapy.

Please write down or bring with you any pharmaceutical medication and any vitamin supplements you may be currently taking, so I may record them in your file. To make the best of our time together, you may want to write down any questions you have concerning your health or about Traditional Chinese Medicine.

CLINIC LOCATION:

Location: Regent Medical Building, #410-2184 West Broadway. On the south side of the street between Arbutus and Yew Streets

Parking: There is free parking on the side streets, meter parking on West Broadway Street, and a pay parking lot, directly behind the building.

Transit: The closest bus stop is West Broadway and Arbutus. The clinic is located on the southeast corner of West Broadway and Yew Street.

Consent Form

Please read carefully and ask your practitioner if you have any questions or concerns.

Traditional Chinese Medicine, acupuncture, and other treatments provided by this clinic have been proven to be highly effective and safe. However, practitioners are required to inform patients that there may be some risks and practitioners cannot anticipate all of the possible complications and risks. In general, the following are some of the side effects that can occur.

- Drowsiness following treatment. If this occurs, you are advised not to drive following treatment
- Minor bleeding or bruising can occur from acupuncture
- Bruising, like that of a hickey, from cupping
- Irritation of the skin due to allergies if a topical lotion or oil is used. Please inform your practitioner if you have any allergies.
- Rarely, fainting can occur, particularly in new patients. To lessen the possibility, it is recommended not to receive a treatment without having consumed some food within 2-3 hours of treatment. It is also advised to inform your acupuncturist if you are nervous of needles or have a history of fainting for any reason.
- In a small percentage of patients, symptoms can become worse before improving. This is generally a sign that healing has begun. If the worsening of symptoms is severe or lasts for more than 2 days, contact your practitioner.

Please inform your practitioner of the following:

- If you are pregnant
- If you have a pacemaker or other electrical implant
- If you have a bleeding disorder
- If you are taking anti-coagulants (blood thinners) or any other medication
- If you have any allergies
- If you have ever felt faint or had any unusual or negative sensation from acupuncture or medical treatments
- If you are at higher risk for infection

I, the undersigned, have read and understood all of the above. I further agree to abide by the requirements set out therein.

(Signature of the patient)

(Signature of the practitioner)

(Printed name of the patient)

(Date)