The Centre of
Integrative Natural Medicine
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The Herbal Baby Program

Initial Consultation Form P. James Tsui Registration #: 979

First Name:	Last Name:	Date of Birth: (mm/dd/yy)	Age:
Street Address:	City:	Prov:	Postal Code:
Telephone(home):	Telephone(work):	Cell:	
Email:		Fax:	
Sex: **F**	Height:	Weight:	Blood Pressure:	Marital Status:	# of children:
Allergies:	Occupation:	Stress Level: (please circle) Low 1 2 3 4 5 6 7 8 9 10 High	
Smoker? (Avg cigarettes/day):	Alcohol? (Type/Avg drinks per week):		
Reason for Visit (Major Medical complaints):	Medical Doctor Name:		
	Other Alternative Health Practitioner Name:		
Referral/How you heard about us:	Date of Visit:		
Disabilities:	Diagnosis from Medical Doctor:		

↓ Please do not write below, for clinic use only↓

Symptoms:

Patterns	
Sleep	
Eating	
Bowel Movement	
Urination	
Traditional Assessment	
Tongue	
Pulse	

Assessment:

Please answer the following questions to the best of your knowledge.

Do you have a single partner with whom you have been trying to conceive? Yes □ No □
Is your partner supportive of your wish to conceive? Yes □ No □
Has your partner been tested for infertility? Yes □ No □
If yes, what were the results?
_____

Do you have any other specific medical, genetic, physical and/or emotional conditions you would like to mention?
_____
_____
_____

Do you have a stressful occupation? Yes □ No □
What would you rate your daily stress level? 1 2 3 4 5 6 7 8 9 10 (10 = high, please circle)
Are you more than 20% below your ideal body weight? Yes □ No □
Are you more that 20% above your ideal body weight? Yes □ No □

Menstrual Cycle History
Age at which menses began:_____
Are your periods painful: Yes □ No □ If yes, how many days does the pain last?____
Which of the two help with pain relief? Please circle HEAT COLD
How many days do you normally bleed? _____
How many days is your cycle? _____ (i.e. 26-30 days)
How heavy is the bleeding? Heavy □ Normal □ Light □
What colour is the blood? Light red□ Red□ Dark Red□ Purple□ brown□ black□
Is there clotting? Yes □ No □
Do you suffer from premenstrual tension? Yes □ No □
Does your face break out prior to or during your period? Yes □ No □
Do your breasts become tender premenstrually? Yes □ No □
Do you bleed or spot between periods? Yes □ No □
Are your menstrual cycles irregular? Yes □ No □
Date of last menstrual cycle:_____
Have your cycles ever changed since they began? Yes □ No □
If so, How_____
_____
Do you ovulate on your own? Yes □ No □ If so, on what day? _____

	Number	Year
How many pregnancies have you had	_____	_____
How many children do you have	_____	_____
How many abortions have you had	_____	_____
How many miscarriages have you had	_____	_____

Have you ever had an abnormal pap smear? Yes □ No □
Do you get yeast infections regularly? Yes □ No □
Do you suffer from chronic vaginal discharge? Yes □ No □

Fertility History

Have you ever been diagnosed with uterine fibroids or polyps? Yes □ No □
Have you ever been diagnosed with endometriosis? Yes □ No □
Have you ever been diagnosed with any pelvic abnormalities? Yes □ No □
Have you ever taken oral contraceptives? Yes □ No □
If yes, when and how long? _____

Have you ever had an IUD? Yes □ No □
If yes, when and how long? _____

Have you ever taken DepoProvera? Yes □ No □
If yes, when and how long? _____

Have you ever taken any gynecological medications other than oral contraceptives? (give medications and reason _____

Have you had fertility treatments? Yes □ No □
If yes when and where and what types?
_____
_____

Have your fallopian tubes been evaluated medically? Yes □ No □
If so, what were the results? _____

Answer yes or no to the following questions.

KIDNEY YIN DEFICIENCY	**YES**	**NO**
Do you have lower back weakness, soreness, pain or knee problems?	□	□
Do you have ringing in your ears or dizziness?	□	□
Is your hair prematurely grey?	□	□
Do you have vaginal dryness?	□	□
Is your mid-cycle fertile cervical mucus insufficient or missing?	□	□
Do you have very pronounced dark circles around or under your eyes?	□	□
Do you have night sweats?	□	□
Would you describe yourself as afraid a lot?	□	□

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KIDNEY YANG DEFICIENCY	**YES**	**NO**
Do you have lower back pain premenstrually?	□	□
Is your low back sore or weak?	□	□
Are your feet cold, especially at night?	□	□
Are you typically colder than those around you?	□	□
Is your libido low?	□	□
Are you often fearful?	□	□
Do you wake up in the night or in the morning because you have to urinate?	□	□
Do you urinate frequently, and is the urine dilute and/or profuse?	□	□
Do you have early morning loose, urgent stools?	□	□
Does your menstrual blood tend to be dull in colour?	□	□
Do you feel cold cramps during your period that respond to a heating pad?	□	□

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SPLEEN QI DEFICIENCY	YES	NO
Are you often fatigued?	☐	☐
Do you have a poor appetite?	☐	☐
Is your energy lower after a meal?	☐	☐
Do you feel bloated after eating?	☐	☐
Do you crave sweets?	☐	☐
Do you have loose stools, abdominal pain or digestive problems	☐	☐
Are your hands and feet cold?	☐	☐
Is your nose cold?	☐	☐
Are you prone to feeling heavy and sluggish?	☐	☐
Do you bruise easily?	☐	☐
Do you think you have poor circulation?	☐	☐
Do you have varicose veins?	☐	☐
Are you prone to worry?	☐	☐
Have you been diagnosed with low blood pressure?	☐	☐
Do you sweat a lot without exerting your self?	☐	☐
Do you feel dizzy or light headed, or have visual changes when you stand up fast?	☐	☐
Is your menstruation thin, watery, profuse or pinkish in colour?	☐	☐
Are you more tired around ovulation or menstruation?	☐	☐
Do you ever spot a few days before your period comes?	☐	☐
Have you ever been diagnosed with uterine prolapse?	☐	☐
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	☐	☐
Have you been diagnosed with hypothyroid or anemia?	☐	☐
Do you have hemorrhoids or polyps?	☐	☐

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BLOOD DEFICIENCY (not necessarily equated with anemia)	YES	NO
Are your menses scanty and/or late?	☐	☐
Do you have dry flaky skin?	☐	☐
Are you prone to getting chapped lips?	☐	☐
Are your fingernails or toenails brittle?	☐	☐
Are you losing hair on your head (not patches but all over)?	☐	☐
Is your hair brittle or dry?	☐	☐
Do you have diminished night time vision?	☐	☐
Do you get dizzy or light headed around your period?	☐	☐

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BLOOD STASIS (often associated with blood deficiency symptoms)	YES	NO
Is your menstrual flow ever brown or black in colour?	☐	☐
Do you feel mid-cycle pain around your ovaries?	☐	☐
Do you have painful unmovable breast lumps?	☐	☐
Do you experience numbness of your ands and feet (especially at night)?	☐	☐
Do you have varicose or spider veins?	☐	☐
Do you have red hemangiomas (cherry red spots) on your skin?	☐	☐
Does your complexion appear dark and sooty?	☐	☐
Do you have chronic hemorrhoids?	☐	☐

Does your menstrual blood contain clots?	☐	☐
Have you been diagnosed with endometriosis or uterine fibroids?	☐	☐
Is your lower abdomen tender to palpation (resisting touch)?	☐	☐
Can you feel any abnormal lumps in your lower abdomen?	☐	☐
Do you have piercing or stabbing menstrual cramps?	☐	☐
Are the veins beneath your tongue twisty and tortuous?	☐	☐
Have you been diagnosed with any vascular abnormality or blood clotting disorder	☐	☐

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LIVER QI STAGNATION	**YES**	**NO**
Are you prone to emotional depression?	☐	☐
Are you prone to anger and/or rage?	☐	☐
Do you become irritable premenstrually?	☐	☐
Do you feel bloated or irritable around ovulation?	☐	☐
Does it feel as if your ovulation last longer than it should?	☐	☐
Are your breast sensitive/sore at ovulation?	☐	☐
Do you experience nipple pain or discharge from your nipples?	☐	☐
Do you have a lot of premenstrual breast distention or pain?	☐	☐
Have you been diagnosed with elevated prolactin levels?	☐	☐
Do you become bloated premenstrually?	☐	☐
Do you have difficulty falling asleep at night?	☐	☐
Do you experience heartburn or wake up with a bitter taste in your mouth?	☐	☐
Are your menses painful?	☐	☐
Do you feel your menstrual cramps in the external genital area?	☐	☐
In the menstrual blood thick and dark, or purplish in colour?	☐	☐

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HEART DEFICIENCY (often associated with heat)	**YES**	**NO**
Do you wake up early in the morning and have trouble getting back to sleep?	☐	☐
Do you have heart palpitations, especially when anxious?	☐	☐
Do you have nightmares?	☐	☐
Do you seem low in spirit or lacking in vitality?	☐	☐
Are you prone to agitation or extreme restlessness?	☐	☐
Do you fidget?	☐	☐
Do you sweat excessively, especially on your chest?	☐	☐

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EXCESS HEAT	**YES**	**NO**
Is your pulse rate rapid?	☐	☐
Are your mouth and throat usually dry?	☐	☐
Are you thirsty for cold drinks most of the time?	☐	☐
So you often feel warmer than those around you?	☐	☐
Do you wake up sweating or have hot flashes?	☐	☐
Do you break out with red acne (especially premenstrually)?	☐	☐
Do you have a short menstrual cycle?	☐	☐
Do you have vaginal irritation or rashes?	☐	☐

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DAMPNESS	YES	NO
Do you feel tired and sluggish after a meal?	☐	☐
Do you have fibrocystic breast?	☐	☐
Do you have cystic or pustular acne?	☐	☐
Do you have urgent, bright or foul-smelling stools?	☐	☐
Does your menstrual blood contain stringy tissue or mucus?	☐	☐
Are you prone to yeast infections and vaginal itching?	☐	☐
Do your joints ache, especially with movement?	☐	☐
Are you overweight?	☐	☐
Do you have a wet, slimy tongue?	☐	☐

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DAMP HEAT	YES	NO
Do you have signs of heat and/or dampness as indicated above?	☐	☐
Do you have foul-smelling, yellow or greenish vaginal discharge?	☐	☐
Are you prone to vaginal and/or rectal itching during your luteal phase or premenstrual phase?	☐	☐

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COLD UTERUS	YES	NO
Do you fit the Kidney Yang deficiency category?	☐	☐
Do you fall into the blood stasis pattern?	☐	☐
Does your lower abdomen feel cooler to the touch that the rest of your trunk?	☐	☐

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15. Please fill in the following chart to the best of your abilities

	Extremely Satisfied	Satisfied	Neutral	Dissatisfied	Extremely Dissatisfied
Health					
Romantic Relationship					
Mother Relationship					
Father Relationship					
Children Relationship					
Sibling Relationship					
Career					
Personal Growth					
Spirituality					
Diet					
Self Image					
Communication Skills					
Leisure Activity					
Travel					
Hobbies					
Finances					
Physical Body					
Home Environment					
Friendships					
Emotional Health					
Stress					
Medical Treatment					

16. Diet: How many servings of the following foods to you consume **daily**?

Protein (1/2 c.)- Meat (poultry, beef, fish, pork) or Vegan (soy, legumes, etc) _____
Dairy (1/4 c.)– (cheese, creams, milk from animals) _____
Fruit (1/2c.) _____
Nuts and seeds (1/4 c.) _____
Grains (1/2 c.) _____
Fresh, Non-starchy vegetables (1 cup) _____
Root vegetables (potatoes, carrots, etc.) (1/2 c.) _____
Oils and fats (1 tbsp) _____

Do you consume fried foods on a weekly basis **Y N**
Do you consume soft drinks/punch/juice daily? **Y N**
Do you consume more than 3 caffeinated beverages daily **Y N**
Do you consume whole grains? **Y N**
Do you frequently snack between meals? **Y N**
Do you consume 3 meals a day? **Y N**
Do you consume processed foods more than three times a week (canned, frozen meals, etc.)? **Y N**

17. Is there anything else you would like to share? Please be precise. _____
_____
_____
_____

The Centre of
INTEGRATIVE NATURAL MEDICINE

INFORMED CONSENT FORM

The services provided in this clinic include: Acupuncture with or without transcutaneous electrical nerve stimulation (TENS) machine, Cupping, Moxibustion, Blood Letting, Chinese herbal medicine, nutritional supplementation, nutritional and lifestyle counseling based on Traditional Chinese Medicine principles. Besides TCM diagnostic methods we also utilize diagnostic methods such as Bio Impedance Analysis (BIA), IgG delayed food sensitivity testing, and Hair Mineral Analysis.

This is to acknowledge that I have been informed and I understand that:

1) Any treatment or advice provided to me as a patient of Practitioner James Tsui R.TCMP, R.Ac is not mutually exclusive of any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.
2) I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.
3) James Tsui have not suggested or recommended me to refrain from seeking or following the advice of another licensed health care provider.
4) The treatment and therapies recommended by James Tsui may be different from those usually offered by a medical doctor or other licensed health care provider.
5) Acupuncture side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the treated area, minor bruising or bleeding, fainting, minor infection, and possible hives.
6) Herbal medicine or nutritional supplements may cause digestive discomfort, nausea, diarrhea or constipation.
7) It is my responsibility to inform the practitioner(s) prior to acupuncture if I have a severe bleeding disorder, clotting disorder, heart condition, pace maker, breasts implant, or if I am or may be pregnant.

I declare that I have received a full and complete explanation of the treatment or services that I may receive at the Centre of Integrative Natural Medicine by James Tsui and hereby authorize and consent to treatment by James Tsui. I intend this consent to apply to all my present and future care at The Centre of Integrative Natural Medicine.

For the safety and well-being of the practitioners and staff at the Centre of Integrative Natural Medicine, I declare the following; (please circle Y for yes and N for no)

I have been diagnosed with Hepatitis B: **Y N** I have been diagnosed with HIV/AIDS: **Y N**
I have been diagnosed with Hepatitis C: **Y N**

As a patient of your clinic, I share my personal information so that you can provide me with the advice, products and services that best suit my needs. You only collect, use and disclose such information in a manner that a reasonable person would consider appropriate in the circumstances. With my consent, you can use and disclose this information to:

* Provide me with the most accurate health advice to suit my needs
* Communicate with me in a timely and efficient manner
* Inform me of any clinic promotions you are holding
* Inform me with the most up-to-date health information via email

The Centre of Integrative Natural Medicine has my permission to use my personal information given on the initial consultation form to reach me regarding appointments or information related to my treatment program. I consent to allowing clinic staff to leave a message on a machine or with any individual at this number regarding appointment information.

Printed Name	Date (dd/mm/yyyy)	Signature

Traditional Chinese Medicine (TCM)

One of the oldest and safest forms of medicine in the world (5000 +years). TCM uses man modalities to treat not only the symptoms, but also the root causes of disease. It works by identifying and correcting any energy imbalances within an individual and restoring the energy to its natural balance and flow. TCM acts in a gentle and gradual manner to assist the body to heal itself in a holistic way. This minimizes any side effects while still being very effective for a wide variety of disorders.

- **Herbal Remedies**: Chinese herbal medicines act in a gentle and gradual manner, assisting the body to heal itself in a holistic way so that the root cause of the problem is treated along with the symptoms. Typical prescriptions can range from 10 or 20 days
- **Acupuncture**: The insertion of ultrafine needles into the skin at specific points along meridians that are key to the healing process. This is the most well-known and commonly used treatment modality. Acupuncture stimulates your body's natural healing mechanism, helping to restore physical and mental balance. Acupuncture has been proven to be effective in treating a wide variety of illness and disorders.
- **Moxibustion**: The use of a dried plant called mugwort which is burnt and produces a therapeutic heat. There are several types of moxibustion; we predominantly use indirect moxibustion which is applying heat close to the skin at specific acupuncture points to dispel cold and dampness from the body.
- **Cupping**: In a typical cupping session, glass cups are warmed using a cotton ball or other flammable substance, which is soaked in alcohol, lit, and then placed inside the cup. removing the oxygen, creating a vacuum and the cup is anchored to the skin. The vacuum draws up the skin to open up the skin's pores, which helps to stimulate the flow of blood, balances and realigns the flow of *Qi*, breaks up obstructions, and creates an avenue for toxins to be drawn out of the body.

  Depending on the condition being treated, the cups will be left in place from 5 to 10 minutes or a small amount of medicated or herbal oil is applied to the skin which allows the practitioner to move the cups over specific acupoints or meridians.
- **Bloodletting**: An ancient technique that calls for using a specialized tool to draw blood from the body to treat a patient. Bloodletting is used to invigorate the smooth flow of *Qi* and blood, dispersing *Qi* and blood stasis, drain excess heat and fire, or induce bleeding to bring down yang rising.

For more information regarding treatments, please speak with your Traditional Chinese Medicine Practitioner.