The Centre of
Integrative Natural Medicine®
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Cancer Care 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: Height:	Weight:	Blood Pressure:	Marital Status:	No. 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 did you hear 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:

Medical Symptoms Questionnaire

Patient Name: _____ Date:_____

Rate each of the following symptoms based on your typical health profile

Point Scale:

Leave Blank-Never (or rarely) 1-Occasionally have the symptoms 2-Frequently have the symptoms

Head:
____Headaches
____Faintness
____Dizziness
____Insomnia (Sleeping disorder)

Eyes:
____Watery or Itchy
____Swollen reddened or sticky eyelids
____Bags or dark circles under eyes
____Blurred or tunnel vision

Ears:
____Itchy ears
____Earaches, ear infections
____Ringing in the ears
____Drainage from ears, hearing loss

Nose:
____Stuffy Nose
____Sinus problems
____Hay Fever
____Sneezing attacks
____Excessive mucus formation

Mouth/Throat:
____Chronic coughing
____Gagging, frequent need to clear throat
____Sore throat, hoarseness, loss of voice
____Swollen or discoloured tongue, gums, lips
____Canker sores

Skin:
____Acne
____Hives or rashes
____Dry Skin
____Hair loss
____Flushing, hot flashes
____Excessive sweating
____Bruise easily

Heart:
____Chest pain
____Irregular or skipped heartbeat
____Rapid or pounding heartbeat
____Have you had heart surgery? (Yes/No)
____Do you have a pacemaker? (Yes/No)

Lungs:
____Chest congestion
____Asthma, bronchitis
____Shortness of breath
____Difficulty breathing

Digestion:
____Nausea, vomiting
____Diarrhea
____Constipation
____Mucus and/or pus in stool
____Bloated Feeling
____Belching, passing gas
____Heartburn
____Intestinal/stomach pains
____Anal itching

Joints/Muscles:
____Pain or aches in joints
____Arthritis
____Stiffness or limitation of movement
____Feeling of weakness or tiredness
____Pain or aches in muscles

Weight:
____Binge eating/drinking
____Craving certain foods
____Excessive weight
____Excessive fat percentage
____Water retention
____Underweight
____Compulsive eating

Energy:
____Fatigue, sluggishness
____Apathy, lethargy
____Hyperactivity
____Restlessness

Mind:
____Poor memory
____Confusion, poor comprehension
____Difficulty in making decisions
____Stuttering or stammering
____Slurred Speech
____Learning disabilities
____Poor Concentration
____Poor physical coordination

Emotions:
____Mood swings – anger, irritable, aggressive
____Anxiety, fear, nervousness
____Depression
____Slurred Speech

Hormones:
____Premenstrual syndrome
(Cramps/moodiness/headaches etc.)
____Infertility
____Lack of interest in sex
____irregular menstrual cycle
____menopausal

Other:
____Frequent illness
____Frequent or urgent urination
____Genital itch or discharge

Please answer each question straight to the point, precise and to the best of your knowledge. If you are unsure, put "I don't know".

1. What is the primary site of your cancer and the date you were first diagnosed? _____
_____

2. Has your cancer metastasized, and if so where? _____
_____
_____

3. What symptoms lead you to your diagnoses of cancer? _____
_____
_____

4. What is your previous medical history, and if you are currently taking any pharmaceutical drugs, please list them below. _____
_____
_____
_____

5. Is there any family history of cancer, if so who and what kind? _____
_____

6. Have you had any conventional (western medicine) treatments? What and When? _____
_____
_____
_____

7. Have you ever had any surgery? What and When? _____
_____

8. When did you last visit your medical doctor? _____
_____

9. Does he/she feel you are in your recovery? _____
_____

10. Rate how you are feeling based on scale 1 through 10:

1 = the best that you have ever felt 10 = the worst you could ever imagine

Pain	_____		
Sleep	_____	Headaches	_____
Appetite	_____	Energy level	_____
Anxiety	_____	Depression	_____

11. Digestive system:

How many bowel movements per day? _____
Do you have constipation or diarrhea? _____
Do you experience heartburn? _____
Do you suffer from abdominal bloating? _____
Do you suffer from gas after meals? _____
Do you have any abdominal soreness? _____

12. What are you currently doing for your health? Circle any that apply:

Exercise	Pharmaceutical	Western Medical Doctor
Vitamins	Medication	Herbal Medicine
Minerals	Natural Medication	Other _____
Meditation	Diet	
Chinese Medicine	Relaxation Techniques	

13. Is there any other medical condition we need to know about?

_____
_____
_____
_____

14. In your own thoughts why do you think you have developed cancer?

_____
_____
_____
_____

15. When was the last time you felt really well/healthy?

_____
_____
_____

16. How does your cancer affect and manifest in your life?

_____
_____
_____
_____
_____

17. Being very honest to yourself and to me, do you believe you can conquer your cancer?

_____
_____
_____
_____

18. 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					

19. Is there anything else you would like to share with me? Please be precise.

_____

_____

_____

_____

_____

20. 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)	_____	Grains (1/2 c.)	_____
Dairy (1/4 c.)– (cheese, creams, milk from animals)	_____	Fresh, Non-starchy vegetables (1 cup)	_____
Fruit (1/2c.)	_____	Root vegetables (potatoes, carrots, etc.) (1/2 c.)	_____
Nuts and seeds (1/4 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**

21. 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.