The Centre of
**Integrative Natural Medicine**
695 Coronation Blvd, Unit 1
Cambridge, ON, N1R 7J9
Phone: (519) 763-6340
info@itsyourhealth.ca

# 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: **M** 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↓**

| Patterns (Practitioner use only) | |
|---|---|
| Sleep | |
| Eating | |
| Bowel Movement | |
| Urination | |
| **Traditional Assessment** | |
| Tongue | |
| Pulse | |

Symptoms:

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 □

**Fertility History**
Have you ever been diagnosed with abnormal sperm production or function? Yes □ No □
If yes, what is the cause and when were you diagnosed?

______________________________________________________________________
______________________________________________________________________

Have you ever been diagnosed with sperm delivery problems (such as premature ejaculation, retrograde ejaculation, certain diseases, structural problems)? Yes □ No □
If yes, what is the cause and when were you diagnosed?

______________________________________________________________________
______________________________________________________________________

Have you ever had radiation or chemotherapy? Yes □ No □
If yes, when and for how long?

______________________________________________________________________

Have you ever taken any medications that impacts male fertility/performance e.g. hormone treatments, Viagra? (give medications and
reason)________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Have you ever been diagnosed STI (sexually transmitted infection)? Yes □ No □
If yes, what was the treatment?

______________________________________________________________________
______________________________________________________________________

Have you had surgery to repair structural damage or problems (e.g. Varicocele)? Yes □ No □
If so, what were the results? ____________________________________________

**Answer yes or no to the following questions.** **YES** **NO**

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 very pronounced dark circles around or under your eyes? | ☐ | ☐ |
| Do you have night sweats? | ☐ | ☐ |
| Would you describe yourself as afraid a lot? | ☐ | ☐ |

/6

KIDNEY YANG DEFICIENCY

| | YES | NO |
|---|---|---|
| Is your low back sore or weak? | ☐ | ☐ |
| Do your feet get 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? | ☐ | ☐ |

/8

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? | ☐ | ☐ |
| Have you been diagnosed with hypothyroid or anemia? | ☐ | ☐ |
| Do you have hemorrhoids or polyps? | ☐ | ☐ |

/18

BLOOD DEFICIENCY (not necessarily equated with anemia)

| | YES | NO |
|---|---|---|
| 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? | ☐ | ☐ |

/6

| | | | |
|---|---|---|---|
| BLOOD STASIS (often associated with blood deficiency symptoms) | | | |
| 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? | ☐ | ☐ | |
| Is your lower abdomen tender to palpation (resisting touch)? | ☐ | ☐ | |
| Can you feel any abnormal lumps in your lower abdomen? | ☐ | ☐ | |
| Are the veins beneath your tongue twisty and tortuous? | ☐ | ☐ | |
| Have you been diagnosed with any vascular abnormality or blood clotting disorder | ☐ | ☐ | |
| | | | /9 |
| LIVER QI STAGNATION | | | |
| Are you prone to emotional depression? | ☐ | ☐ | |
| Are you prone to anger and/or rage? | ☐ | ☐ | |
| Do you have difficulty falling asleep at night? | ☐ | ☐ | |
| Do you experience heartburn or wake up with a bitter taste in your mouth? | ☐ | ☐ | |
| | | | /4 |
| HEART DEFICIENCY (often associated with heat) | | | |
| 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? | ☐ | ☐ | |
| | | | /7 |
| EXCESS HEAT | | | |
| 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? | ☐ | ☐ | |
| | | | /6 |
| DAMPNESS | | | |
| Do you feel tired and sluggish after a meal? | ☐ | ☐ | |
| Do you have cystic or pustular acne? | ☐ | ☐ | |
| Do you have urgent, bright or foul-smelling stools? | ☐ | ☐ | |
| Do your joints ache, especially with movement? | ☐ | ☐ | |
| Are you overweight? | ☐ | ☐ | |
| Do you have a wet, slimy tongue? | ☐ | ☐ | |
| | | | /6 |

**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 | | | | | |

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 more than 3 caffeinated beverages daily **Y N**

Do you frequently snack between meals? **Y N**

Do you consume soft drinks/punch/juice daily? **Y N**

Do you consume whole grains? **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**

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 and/or Meredith Ovenden 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 and Meredith Ovenden 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 and/or Meredith Ovenden 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 and/or Meredith Ovenden. 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.**