



HEALING ELEMENTS

Healing as Ancient as the Elements

Integrative Health Group

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Patient Intake form

Date: _____ Name: _____ Date of Birth (D/Month/Y): ___/___/___

Address _____

City _____ Province _____ Postal Code _____

Home Tel. _____ Bus/Cell _____

E-Mail _____

Emergency Contact _____ Tel. # _____

How did you find out about Healing Elements? _____

Prior Acupuncture Care: Yes/No

Name of practitioner: _____ Telephone: _____

Physiotherapist, Acupuncturist, Other: _____ If so when? _____

Results Achieved: Excellent Good Fair Poor

Medical Doctor:

Name: _____ Telephone: _____

Address: _____

Date of last appointment: _____ Date of last physical: _____

Reason for consulting our office today:

Expectations: _____

Medicines:

Prescription drugs you are currently taking:

For what condition?

Over-the-counter medication you are currently taking:

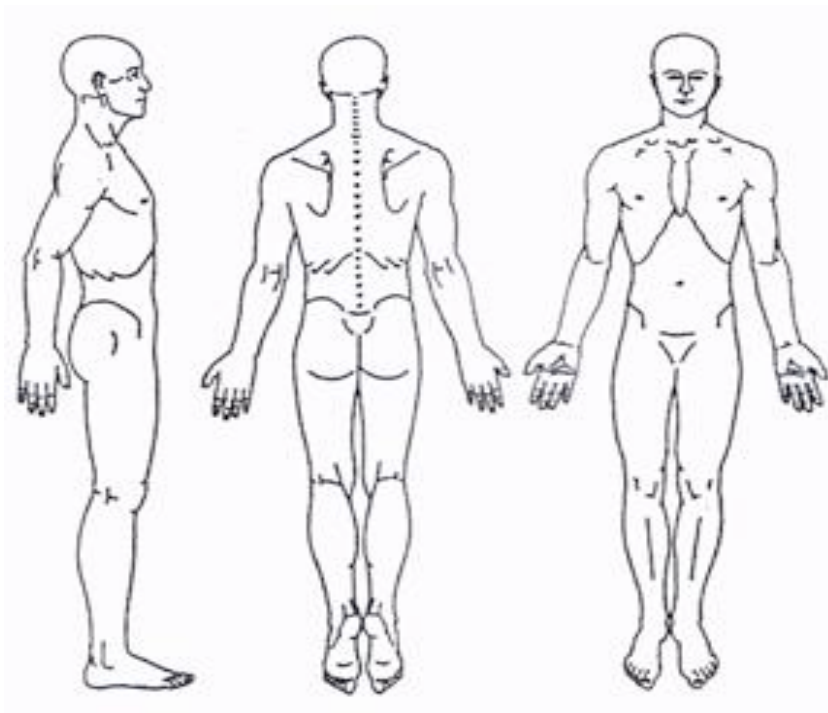
For what condition?

Major hospitalizations: If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

Any allergies?

Please draw the location of any pain or discomfort on the images below.
Use the symbols shown to represent the type(s) of pain:

D = Dull B = Burning N = Numb S = Stabbing/Sharp T = Tingling C = Cramping



Place an X on the line to indicate your over-all sense of well-being during the past month.

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Worst you have ever been

Best you have ever been

Chinese Medical Intake

This intake is not only used as a diagnostic tool but as an educational device as well. It will aid you in becoming acquainted with the language of Chinese Medicine. Check the symptoms you have experienced during the last six months. (Example: \sqrt fatigue) Circle the check on those that have been the most troublesome. Please remember that all of this personal information is kept in strict confidence.

Patterns of Depletion

Deficient Qi

- weak, lethargic, weary
- lowered libido
- apathy
- dull thinking or feeling
- excessive need for sleep
- susceptible to cold, flus, allergies
- prolonged recovery following illness
- pasty, pale complexion
- shortness of breath
- aversion to talking
- perspires easily with exertion
- easily chills
- frequent, profuse urination

Slack Qi

- perspires easily at rest
- atony or prolapse of stomach, intestines, anus
- constant diarrhea or lack of bowel movement
- hemorrhoids, varicose veins
- dizzy or weak after meal or bowel movement
- well-being followed by sudden exhaustion

Deficient Moisture

- parched, thirsty
- extreme dryness of the skin or mucous membranes
- scant secretions and urination
- constipation
- uncomfortable feeling of heat in the body
- low afternoon fever with sweating
- hot flashes
- night sweats
- unstable blood sugar, emotional moodiness
- persistent dry cough
- dry sore throat
- flushed face

Slack Moisture

- excessive secretions from the eyes, nose, mouth, skin, vagina
- seminal incontinence or premature ejaculation
- frequent urination or incontinence
- dizzy or weak after sex (female)

Deficient Blood

- restless fatigue
- emotional sensitivity
- insomnia and anxious sleep
- itching, prickling skin or scalp
- dryness without thirst
- blurred or weak vision
- thinning hair
- light headed when fatigued
- dry or hard stool
- anemia
- muscle cramps
- lack of semen
- scanty or frequent menstruation
- insufficient lactation
- pale, sallow complexion
- poor skin healing
- palpitations
- postpartum weakness or anemia
- tendency to miscarry
- dizzy or weak after sex (male)

Slack Blood

- easy bruising or bleeding
- chronic ulcers of mouth, throat, stomach, intestines, vagina
- excessive bleeding during menses, pregnancy, postpartum or menopause
- bleeding hemorrhoids and blood in stool, urine or sputum

Diminished Essence

- profound weakness
- flaccid and stiff
- atrophy or muscles and organs
- sagging or wrinkling skin
- diminished sexual arousal and pleasure
- infertility or early menopause
- repeated miscarriages
- loosening or loss of teeth
- thinning or graying of head and pubic hair
- loss of elasticity of tendons, ligaments, and muscles
- decline of memory
- progressive loss of weight or emaciation
- compromised immunity

DISTURBED SHEN

- restlessness and agitation
- emotionally unstable
- hypersensitivity to pain or insult
- sudden rage, grief or panic
- constant anxiety, incessant worry, or mental confusion
- easily startled or fatigued
- erratic sleep, insomnia
- delirium
- dull, glazed or bizarre look in eyes and face

PATTERNS OF CONGESTION

STAGNANT QI

- stuffy head
- mild nausea or fullness in chest or abdomen
- gas pains, cramps, tension in stomach or intestines
- hiccups, belching or flatulence
- constipation or irregular bowel movements
- vague or intermittent pains

OBSTRUCTED QI

- acute generalized discomfort, fullness, pressure in head, chest, limbs, or abdomen
- abdominal distention but unable to release gas
- wheezing or non-specific chest pain
- difficulty swallowing
- stitch or acute pain in abdomen, ribs, or flanks
- fullness or dull pain under ribs or sternum

STAGNANT MOISTURE

- soft or loose stool
- puffy eyes, face, hands or ankles
- frequent, scanty or difficult urination
- lethargic in humid weather
- soft swellings, nodules, cysts, enlarged lymph nodes
- premenstrual soreness and swelling of breasts
- sore muscles or joints
- thirsty but averse to drinking

OBSTRUCTED MOISTURE

- swollen or heavy head and limbs
- swollen, sore muscles and joints
- excess saliva, mucus or perspiration
- constipation alternating with watery, loose stool
- scanty or absent urine
- edema of hands, feet, face or abdomen
- thick, nauseated feeling in mouth, stomach and head

STAGNANT BLOOD

- easy bruising
- cold hands and feet
- irregular or painful menses
- mottling, numbing and chilling of limbs
- sharp pains in head, eyes, joints, limbs, breasts or organs
- mid-cycle or premenstrual pain or tender breasts
- painful hemorrhoids, cysts or lumps

OBSTRUCTED BLOOD

- angina
- severe or constant headache
- traumatic bruises, swellings and sprains
- persistent stabbing or throbbing pains (especially in joints or viscera)
- pain aggravated at night or from inactivity
- severe cramping, numbness or paralysis
- dark red or purple complexion
- purple lesions on skin, tongue, mouth or lips
- severe menstrual cramps with dark blood or clots
- hard or immobile lumps, masses or organs

ADVERSE CONDITIONS

HEAT

- fever associated with infection, inflammation or emotional upset
- pain, soreness, swelling or dryness accompanied by a sensation of heat or burning
- sores or infections with green or yellow pus
- yellow, green, or foul smelling discharge from ears, nose throat, anus, vagina, or urethra
- extreme thirst with a craving for cold foods or drink
- red eyes, ears, nose, lips, face, skin
- feeling of heat in limbs, abdomen, chest, head, or genitals
- aggravation from alcohol, fried, or spicy foods

COLD

- lack of thirst
- listless and weak
- cold feeling in limbs, head, chest, abdomen or genitals
- pale face with cold, clammy hands and feet
- loose stool or profuse urination in cold climate or after eating raw or cold foods and liquids
- pain in head, chest, limbs or joints in the cold
- pale, purplish skin, nail beds, lips or tongue
- craving for warm, cooked foods and hot drinks

DAMP-HEAT

- dryness or thirst without desire to drink
- feeling of heat in stomach or chest with a nauseating taste in mouth
- sticky yellow or green discharge from nose, throat bronchi, urethra, or vagina
- hot flashes with profuse perspiration
- fever or heat not relived by perspiring or drinking
- loose or sticky stool streaked with mucus or pus
- burning, red, oozing sores, boils, pimples, blisters or rashes
- hot, heavy, dull feeling in the head, chest, abdomen or limbs
- symptoms worse from heat and/or humidity, and sweet, spicy or oily foods

EXTERNAL WIND

- itching or prickly sensations of skin, ears, eyes, nose: sneezing, headache
- unpredictable or migrating pains
- dizziness or headache with cold, flu, or allergy
- muscle soreness or shivering when exposed to wind, drafts or changing temperatures (Chinooks)
- numbness or pain of face or scalp
- neck stiffness or spasm
- symptoms worse from drafts and changing weather

INTERNAL WIND

- trembling hands, feet, head
- spasms, twitches, cramps, of nerves, muscles and viscera
- disequilibrium, incoordination
- contracture or quivering of tongue
- vertigo, motion sickness, hypertension
- headache with vertigo, numbness, spasms, parasthesia (strange sensations)
- seizures, sequellae of stroke or T.I.A.
- symptoms worse from wind, Chinooks, or changing from sitting to being upright

PHLEGM (congealed moisture)

- dizziness or fullness in head from mucus
- nausea with phlegm in chest or throat
- thick, sticky secretions from ears, eyes, nose, throat, mouth, anus, vagina or urethra
- firm, mobile lumps or enlarged lymph nodes
- worse in humid environment or from eating sticky, greasy, oily foods, milk products, sugar
- hardened nodules or cysts

ORGAN NETWORK DISTURBANCES

LIVER NETWORK

- dry eyes
- blurred or unclear vision
- nervous, irritable, short tempered
- easy chilling of arms, hands, legs, feet
- coarse, brittle nails or hair
- touchiness from heat, wind, noise, bright light
- numbness, tingling of limbs when inactive
- muscle cramps of pelvis, sides, hips, feet
- tension in shoulders, neck, sacrum, hips, legs
- stitching pains under diaphragm, between ribs, groin or pelvis
- dry or hard stool, tension or cramping in colon
- high pitched or loud ringing in the ears(tinnitus)
- dizzy, queasy, flushed or headache from hunger, tension, anger
- hypersensitive genital organs

HEART NETWORK

- anxiety, dread
- restless and excitable
- easily confused or disoriented
- mood swings (laughs easily, cries easily)
- insomnia when nervous, worried or excited
- excitement, anxiety and fatigue causing light, restless sleep and vivid dreams or nightmares
- cravings for cool drinks, hot, spicy foods
- sores of mouth and tongue
- easily overheats and perspires
- easy blushing of face, chest, neck, and ears
- burning, sensitivity or irritation of mouth, tongue, urethra, vagina or anus
- frequent urination or bowel movements from nervousness
- palpitations when nervous, upset or fatigued

SPLEEN NETWORK

- tender muscles
- difficult bowel movements
- slow digestion or indigestion
- frequent abdominal gas or bloating
- loose stool from raw or cold foods, cold liquids
- variable appetite
- lingering hunger after meals
- hard to gain, lose or regulate weight
- easily worried, obsessed
- difficulty focusing, distractible
- overwhelmed by details, upset by changes
- water retention, puffiness, heaviness of head
- easy bruising, prolonged or heavy menses
- lethargy and inertia

LUNG NETWORK

- weakness of chest
- respiratory allergies
- runny nose or stuffy sinuses
- frequent and lingering colds, coughs, throat clearing or laryngitis
- morning attacks of coughing or sneezing
- constant phlegm in chest or throat
- shortness of breath, chest pain, or wheezing from fatigue or exertion
- dryness and tightness of mucous membranes or skin
- urge to urinate after laughing, coughing or sneezing
- skin rashes, eczema, hives
- easily disappointed or offended
- sensitive to wind, cold and dryness
- stiffness of joints and muscles

KIDNEY NETWORK

- puffiness around eyes
- diminished libido
- lack of sexual secretions
- loss or thinning of pubic hair
- early cessation of menses, irregular cycle
- profuse or scanty urination
- frequent or difficult urination
- decreased range of motion of spine and joints
- difficulty conceiving or carrying to term
- weak, sore low back, hips, knees, ankles or feet
- lack of stamina and endurance
- need to sleep a lot
- diminished motivation and apathy
- forgetfulness and mental dullness
- puffiness or swelling of feet and ankles
- weak vision dull hearing
- low humming or buzzing in ears
- sore throat from fatigue or in the morning
- easily defeated and disgruntled

FOR WOMEN

Age of first period _____ Date of last period _____ Number of pregnancies _____ Number of births _____

Number of days between your periods (your cycle) _____ Number of days of flow _____

Colour of flow:	Amount of flow:	# of pads/tampons you use per day:	Pain and cramping
<input type="checkbox"/> pale/light red	<input type="checkbox"/> spotting	<input type="checkbox"/> 1 st day	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> red	<input type="checkbox"/> light	<input type="checkbox"/> 2 nd day	<input type="checkbox"/> before flow <input type="checkbox"/> mild
<input type="checkbox"/> bright red	<input type="checkbox"/> even throughout	<input type="checkbox"/> 3 rd day	<input type="checkbox"/> during flow <input type="checkbox"/> moderate
<input type="checkbox"/> dark red	<input type="checkbox"/> heavy	<input type="checkbox"/> 4 th day	<input type="checkbox"/> after flow <input type="checkbox"/> severe
<input type="checkbox"/> dark red/brown		<input type="checkbox"/> + days	
<input type="checkbox"/> clots			

Other symptoms related to menses:

<input type="checkbox"/> Discharge	<input type="checkbox"/> PMS	<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Swollen Breasts	<input type="checkbox"/> Painful Breasts	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Increased Appetite		<input type="checkbox"/> Decreased Appetite		

Have you ever been diagnosed with:

<input type="checkbox"/> fibroids	<input type="checkbox"/> endometriosis	<input type="checkbox"/> ovarian cysts	<input type="checkbox"/> fibrocystic breasts	<input type="checkbox"/> PID
<input type="checkbox"/> polycystic ovary syndrome		<input type="checkbox"/> STD _____		

Fertility Information

Has a physician diagnosed a difficulty with fertility due to:

<input type="checkbox"/> Female factor	<input type="checkbox"/> Male factor	<input type="checkbox"/> Unexplained	<input type="checkbox"/> Other _____
# of TVF procedures _____		# of IUI procedures _____	

Chinese Medicine & Acupuncture Disclosure Statement & Informed Consent

Clinic Fee Schedule (due at time of service) Prices include GST

Adult first treatment \$115.00 Child first treatment \$85.00

Adult follow-up \$85.00 Child follow-up \$60.00

Please note no children under 18 years of age are permitted treatment without a guardian present in the clinic during the duration of the treatment.

Package of 6 treatments (Adult)- \$450.00 (does not include first treatment)

Package of 12 treatments (Adult) - \$840.00 (does not include first treatment)

Insurance: We do not bill insurance. We will provide you with a receipt for your insurance company upon request.

All appointments that are cancelled/rescheduled with less than 24 hours notice and appointments missed without notice will be charged a fee of \$40.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with Dr. McCollum &/or Associates. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

Date: _____

Signature of Patient or Person authorized to consent Relationship or Authority of Representative