Consultation Form

First Name (Print) _____ Last Name (Print) _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip Code _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

E-mail address _____ Date _____

Referral _____ Nationality _____ Occupation _____

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them *directly opposite* on the right side. Be sure to mention any drugs, vitamin supplements, or other medicinal substances you are taking.

Complaints:	How long have you had it?	Treatment:

Brief Health History: (list major diseases, surgeries, etc.)

How many times per year do you get a cold or the flu?_____

Family Medical History:

What other medication and/or supplements are you taking? How long have you taken them?

Emotions: ____**Normal** ____**Problem**

____Depression ____Sadness ____Panic attack ____Sensitive

____Worries ____Overly excited ____Angry ____Anxiety

Describe:_____

Energy: ____**Normal** ____**Problem** ____Low ____Up and down

____Exhausted ____Hyperactive ____Nervous energy ____Abundant

Describe:_____

Sleep Pattern: ____**Normal** ____**Insomnia**

Falling Asleep: ____Sometimes difficult ____Always difficult ____Sometimes very difficult

____Always very difficult ____Sleepy in daytime ____Take naps

Waking up: ____Times per night ____Wake up too early

____Wake up at night and cannot go back to sleep again

Sleep Quality: ____Deep ____Light ____Poor ____Many dreams

____Bad dreams ____Grinding teeth ____Talking in sleep ____Other

Describe:_____

Diet: Any special diet?

____**Food cravings**: ____Sugar ____Salt ____**Food allergies**

Describe:_____

Temperature: ____**Normal** ____**Abnormal**

____Feel cold easily ____Cold hands ____Cold feet ____Feel hot easily

____Alternating hot & cold ____Hot flash ____Sensitive to weather changes

Describe:_____

Sweating: ____**Normal** ____**Abnormal** ____Too easily ____Too much

____Difficult ____Too little ____Night sweats ____Other

Describe:_____

Sensitivity and Allergy: ____**No** ____**Yes**

Temperature: ____Cold ____Hot ____Dampness ____Light

____Noise ____Airborne particles ____Drugs ____Other

Describe:_____

Appetite and Digestion: ____**Normal** ____**Abnormal**

____Rapid hungering ____Poor appetite ____Nausea ____Anorexia

____Hungry, but no desire to eat ____Bloating ____Gas ____Other

Describe:_____

Bowel Movement: ____**Normal** ____**Abnormal** ____**Time of day**

____Constipation ____Diarrhea ____Loose ____Watery ____Incomplete

____Hard and dry ____Strong smell ____With mucus ____With blood ____Other

Describe:_____

Body Weight: ____**Normal** ____**Overweight** ____**Underweight**

If overweight: ____How many pounds would you like to lose?

____How many years ago did you first start to gain weight?

____Are you following a weight control program at this time?

Describe:_____

Drinking: ____**Normal** ____**Abnormal**

____Thirsty Dry mouth ____Drink a lot

____Dry mouth but no desire to drink

____Not thirsty, but drink a lot of water anyway

Describe:_____

Urination: ____**Normal** ____**Abnormal**

____Frequent ____Urgent ____Burning ____Painful ____Cloudy

____Dark color ____Foul smell ____Bloody ____Difficult ____Retention

____Number of time per day ____Number of times you get up to urinate at night ____Other

Describe:_____

Eye, Ear, and Nose: ____**Normal** ____**Abnormal**

Describe:_____

Sex Function: ____**Normal** ____**Abnormal**

Describe:_____

Menstrual Cycle: Age of onset: _____years old Date of last period: ____/____/

____**Regular** ____**Irregular** ____How many days between cycles?

____How many days did it last?

Color: ____Pale red ____Dark red ____Bright red ____Purplish

Were there clots? ____Yes ____No

Menstrual Pain: ____Yes ____No

____Before flow ____During flow ____After flow

____Abdomen ____Back ____Breast

Emotion around period: ____Normal ____Abnormal

____Before flow ____During flow ____After flow ____Depression

____Irritability ____Anger ____Sadness ____Crying ____Other

Describe:_____

Addictions: ____Tobacco ____Alcohol ____Others

Describe:_____

Any other disorders or abnormalities:

Describe:_____

PATIENT INFORMED CONSENT FOR ACUPUNCTURE AND/OR HERBS

I, _____, hereby voluntarily consent to be treated with acupuncture and/or Chinese Herbs, administered by Ton Shen Health, Inc.. I understand that acupuncture is performed by the insertion of fine, pre-sterilized, disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese Herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination and diagnosis. In the course of the evaluation, there may be reference to the state of various "organs", such as heart, liver, spleen, kidneys, etc., which actually refers to energetic channels of the same name.

I acknowledge the fact that the practitioners of Ton Shen Health, Inc. are not and do not profess to be a western-trained medical doctors and do not use or advise on the use of medically-prescribed pharmaceuticals or medical treatments, nor do the practitioners give any substances by injection.

I acknowledge that all the Life Rising herbal products are not approved by Food and Drug Administration of USA (FDA).

I acknowledge that the practitioners of Ton Shen Health, Inc. have completed a minimum of three years training in Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the State of Illinois.

If clinical data is gathered it will be without names and may be used for statistical data and research. According to federal policy, we need you written consent for the following:

Do we have your permission to make appointment confirmation calls? Yes or No
If yes, what number(s) shall we call?

Home _____ May we leave a message? _____
Cell _____ May we leave a message? _____
Work _____ May we leave a message? _____

Signature: _____ Date:_____ Witnessed by:_____

Patient or guardian Practitioner