Catherine Brown
Riverina Natural Therapies
92 Fitzmaurice Street
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Ph: 0418 607 408
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GENERAL PATIENT INFORMATION

Please complete all questions if possible

First Name: ____________________________ Last Name: __________________________

Sex: ____________________________ Date of Birth: __________________________

Street Address: ____

Suburb: ____________________________ Postcode: __________________________

Phone No. (Best Contact): _______________

Email: ____

Do you have private health insurance? _________________________ Yes / No

Name of Fund: ____________________________________

Are you covered for complementary therapies?______ Yes / No

How did you hear about us?____

What is your occupation? ____

Do you enjoy your work? ____

How many hours per week do you work? _____________________________________

Is it stressful? ____

What are your duties? ____

Main Problems you would like us to help you with: ____

____

How long ago did this problem begin? ____

Have you been given a diagnosis for this problem? __ Yes / No

If so, what and by whom? ____

What kind of treatments have you tried? _______________________________________

____

On a scale of 1-10, how would you rate your daily energy level (10 being best)? __________

Are your bowel movements regular? ____

How many times per day/week? _____________________________________

Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

____

Do you experience urinary frequency, urgency, burning, dribbling, retention? __________ Yes / No

What colour/shade of yellow is it? ___________________________________

Do you have a history of urinary tract infections? __________________________________ Yes / No

How many glasses of water do you drink in a day? _________________________________

Please describe in general what you eat? (Organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

What do you crave (sweet, spicy, salty) ________________________________

Do you have trouble falling asleep? ____ Yes / No

Do you wake throughout the night? ____ Yes / No

Are you a light sleeper? ____ Yes / No

How many hours of sleep per night do you have? ___________________________________

Do you have vivid dreams? ____ Yes / No

Do you have night sweats? ____ Yes / No

If you were asked to describe yourself from an emotional standpoint, what would you say?

ie: irritable, worrier, anxious, sad, impatient, stressed, etc. ___________________________

____

Do you have a regular exercise program? ____ Yes / No

If yes, please describe? ____

____

No. of cigarettes smoked per day? ____

How much coffee, tea, or cola do you drink per day? ____________________________________

Have you ever taken recreational drugs? ____ Yes / No

Do you still take them? ____ Yes / No

Do you use alcohol? ____ Yes / No

No. of Drinks per day? ___________

Do you use a hot tub? ____ Yes / No

No. of times per week? __________

Drug Allergies

Are you allergic to any medications that you know of? If yes, please list them below:

Medication	Reaction
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________
_____________________________________	_____________________________________

Current Medications or Supplements

Medication / Supplement	Dose	Frequency
_________________________________	__________	_______________________________
_________________________________	__________	_______________________________
_________________________________	__________	_______________________________
_________________________________	__________	_______________________________
_________________________________	__________	_______________________________

Medical Conditions

Please circle **Yes** for any / all that apply to **you**

German Measles (Rubella) _______________Yes

Migraine ______________________________Yes

Prolonged Dizziness ____________________Yes

Thyroid Problems ______________________Yes

Pneumonia ____________________________Yes

Tuberculosis ___________________________Yes

Asthma _______________________________Yes

Bronchitis _____________________________Yes

Other Lung Conditions __________________Yes

Heart Attack ___________________________Yes

Heart Murmur _________________________Yes

Rheumatic Fever _______________________Yes

Other Heart Conditions _________________Yes

High Blood Pressure ____________________Yes

Gastric / Duodenal Ulcer ________________Yes

Hepatitis ______________________________Yes

Intestinal Bleeding _____________________Yes

Bleeding Tendency _____________________Yes

Problems with Anaesthesia ______________Yes

Diabetes ______________________________Yes

Kidney Stones _________________________Yes

Kidney Infection _______________________Yes

Other Kidney Disorders _________________Yes

Bladder Infection ______________________Yes

Rheumatoid Arthritis ___________________Yes

Other forms of arthritis _________________Yes

Lupus Erythematosus ___________________Yes

Paralysis ______________________________Yes

Neurological Disorders __________________Yes

Thrombophlebitis ______________________Yes

Varicose Veins ________________________Yes

Other (please list) ____

____

Previous Surgeries

Have you ever had surgery? __________ Yes / No. If yes, please complete this section

Procedure	Date	Indication	Outcome
__________________________	_________	_____________________	______________________
__________________________	_________	_____________________	______________________
__________________________	_________	_____________________	______________________
__________________________	_________	_____________________	______________________

FAMILY MEDICAL HISTORY

Is there a history of any of the following conditions in the **family**?
Please select any / all that apply

Medical Condition	Select	Details
Diabetes _______________________	Yes	____
Heart Disease ___________________	Yes	____
High Blood Pressure _____________	Yes	____
Kidney Disease _________________	Yes	____
Multiple Births _________________	Yes	____
Mental Retardation______________	Yes	____
Birth Defects ___________________	Yes	____
Inherited Diseases_______________	Yes	____
Rheumatoid Arthritis ____________	Yes	____
Mental Illness __________________	Yes	____
Cancer _________________________	Yes	____
Allergies (ie: Food, Dust) ________	Yes	____
Drug Abuse _____________________	Yes	____
Thyroid Disease_________________	Yes	____
Lupus Erythmatosis______________	Yes	____
Blood Disorders_________________	Yes	____
Breast Cancer __________________	Yes	____
Ovarian Cancer _________________	Yes	____
Uterine Cancer _________________	Yes	____
Other Cancer___________________	Yes	____
Sickle Cell Disease _______________	Yes	____
Cystic Fibrosis __________________	Yes	____
Other __________________________	Yes	____
Other __________________________	Yes	____

MALE PATIENT SPECIFIC INFORMATION
Please select any / all that apply to you?

Kidney Yin / Jing Deficiency
Do you have a lower back weakness, soreness or pain or knee problems? ______________ Yes / No

Do you have ringing in your ears or dizziness? Is your hair prematurely grey? ___________ Yes / No

Do you have dark circles around or under your eyes? ______________________________ Yes / No

Do you have night sweats or heat up at night? ___________________________________ Yes / No

Are you prone to hot flushes? ____ Yes / No

Do you experience fear in your life? ____ Yes / No

Kidney Yang Deficiency
Is your lower back sore or weak? ____ Yes / No

Are your feet and hands cold? ____ Yes / No

Are you typically colder than those around you? __________________________________ Yes / No

Is your libido low? ____ Yes / No

Do you wake at night / early in the morning because you have to urinate? _____________ Yes / No

Do you urinate frequently and is the urine diluted? _______________________________ Yes / No

Do you have early morning loose bowels? _______________________________________ Yes / No

Feel tired after sex / ejaculating?____ Yes / No

Spleen Qi Deficiency
Are you often fatigued? ____ Yes / No

Is your energy lower after a meal? ____ Yes / No

Do you feel bloated after eating? ____ Yes / No

Do you crave sweets? ____ Yes / No

Do you have abdominal pain or digestive problems? _______________________________ Yes / No

Are your hands and feet cold? ____ Yes / No

Is your nose cold? ____ Yes / No

Are you prone to heaviness or fogginess in the head? ______________________________ Yes / No

Do you bruise easily? ____ Yes / No

Do you have poor circulation? ____ Yes / No

Do you have varicose veins? ____ Yes / No

Are you prone to worry? ____ Yes / No

Have you been diagnosed with low blood pressure? _______________________________ Yes / No

Do you sweat a lot without exerting yourself? ____________________________________ Yes / No

Do you feel dizzy or light headed, or have visual changes when you stand up fast? _______ Yes / No

Have you ever been diagnosed with uterine prolapse? ______________________________ Yes / No

Are you often sick or do you have allergies? ____ Yes / No

Have you been diagnosed with anaemia? ____ Yes / No

Do you have haemorrhoids or polyps? ____ Yes / No

Blood Deficiency

Do you have dry flaky skin? ____ Yes / No

Are you prone to getting chapped lips? ____ Yes / No

Are your fingernails or toenails brittle? ____ Yes / No

Are you losing hair on your head? ____ Yes / No

Is your hair brittle or dry? ____ Yes / No

Do you have diminished night-time vision? ____ Yes / No

Do you get dizzy or light headed around your period? ________________________________ Yes / No

Do you get shortness of breath? ____ Yes / No

Do you experience palpitations (feel your heart beat in your chest)? ___________________ Yes / No

Blood Stasis

Do you experience periodic numbness of your hand or feet? __________________________ Yes / No

Do you have varicose veins or spider veins? _______________________________________ Yes / No

Is your lower abdomen tender to palpation (touch)? __________________________________ Yes / No

Do you have dark spots in your vision? ____ Yes / No

Liver Qi Stagnation

Are you prone to emotional depression? ____ Yes / No

Are you prone to anger or rage? ____ Yes / No

Do you have difficulty falling asleep at night? ______________________________________ Yes / No

Do you experience heartburn or wake up with bitter taste in your mouth? ______________ Yes / No

Do you have cold hands and / or feet?____ Yes / No

Heart Deficiency

Do you wake up early in the morning and have trouble getting back to sleep? ___________ Yes / No

Do you have heart palpitations, especially when anxious? ____________________________ Yes / No

Do you have nightmares? ____ Yes / No

Do you seem low in spirit or lacking in vitality? ______________________________________ Yes / No

Are you prone to agitation or extreme restlessness? __________________________________ Yes / No

Do you fidget? ____ Yes / No

Do you sweat excessively, especially on your chest? __________________________________ Yes / No

Excess Heat

Is your pulse rate rapid? ____ Yes / No

Are your mouth and throat usually dry? ____ Yes / No

Are you thirsty for cold drinks most of the time? ___________________________________ Yes / No

Do you often feel warmer than those around you? ___________________________________ Yes / No

Do you wake up seating or have hot flushes? _____________________________________ Yes / No

Do you break out with red acne? ____ Yes / No

Dampness

Do you feel tired and sluggish after a meal? ______________________________________ Yes / No

Do you have cystic or pustular acne? ____ Yes / No

Do you have oedema / swelling? ____ Yes / No

Do your joints ache, especially with movement? ____________________________________ Yes / No

Are you overweight? ____ Yes / No

Do you have damp, sticky, unformed stools? ______________________________________ Yes / No

MEDICAL HISTORY

Have you initiated any pregnancies in the past _______________________________________ Yes / No

Number of pregnancies? ____

Number with current partner? ____

When was the most recent pregnancy? ____

Have you ever had a semen analysis? ____ Yes / No

If yes, when? ____

Provide the following results of the analysis:

Volume ____

Count (million cell/ml) ____

Motility (%) ____

Morphology (% normal forms) ____

pH ____

Agglutination (clumping) ____

Please provide copies of all sperm test analysis

Have you ever had any of the following tests or procedures?

Test / Procedure	Date	Result	Comment
FGS	______________	____________________	__________________
LG	______________	____________________	__________________
Testosterone	______________	____________________	__________________
TSH	______________	____________________	__________________
Anti-sperm antibodies	______________	____________________	__________________
Vasectomy	______________	____________________	__________________
Vasectomy Reversal	______________	____________________	__________________
Testicular biopsy	______________	____________________	__________________
Varicocele ligation	______________	____________________	__________________
Undescended testicle	______________	____________________	__________________

How long have you and your partner been trying to conceive? ________________________

Are you currently undergoing assisted reproductive fertility treatments (IUI, IVF, ICSI, Superovulation, etc.) ____ Yes / No

If yes, at what Clinic? ____

How would you define your sexual energy? ________________________ Below Normal / Normal

Do you or did you have an undescended testicle?__________________________________ Yes / No

Have you ever been diagnosed with a varicocele __________________________________ Yes / No

Have you have had any urologic surgeries? ______________________________________ Yes / No

Do you have difficulty getting / maintaining an erection during sex? __________________ Yes / No

Do you have an erection when you wake up in the morning _________________________ Yes / No

Do you experience difficulty ejaculating during sex? ______________________________ Yes / No

Do you ejaculate quickly during sex? ____ Yes / No

Do you have difficulty reaching an orgasm? ______________________________________ Yes / No

How many times per week would you ejaculate? __________________________________ Yes / No

How many times do you have sex with your partner per week? ______________________ Yes / No

Have you had exposure to any known environmental toxins or hormones? _____________ Yes / No

Have you experienced any penile discharge? ______________________________________ Yes / No

Do you regularly experience nocturnal emission? __________________________________ Yes / No

Do you currently have any prostate conditions? __________________________________ Yes / No

Do you or have you ever had urinary infections or STD's? ___________________________ Yes / No

Have you ever been diagnosed with small or soft testis? ____________________________ Yes / No

Have you been checked for a blockage of your reproductive tract? ___________________ Yes / No

Other Comments ____

____

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CANCELLATION & RESCHEDULING POLICY CLIENT AGREEMENT

Welcome to Fertile Qi, we are delighted to have you as a patient & look forward to providing you with the highest quality care. We understand there are times when you may need to cancel and / or reschedule your appointment and we are pleased to accommodate your needs.

However due to increasing demand for our services we are implementing a cancellation fee. Therefore, it is our policy that all cancellations and / or rescheduled appointments are to please take place 24 hours prior to the date of your originally scheduled appointment.

If you are reasonably unable to fulfil these requirements or you miss a booked appointment, 50% of the scheduled service fee will be charged and an account issued.

This policy allows us time to schedule another patient that would also benefit from treatment. Thank you for your understanding.

Full Name ______________________________

Signature ______________________________

Date ______________________________

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INFORMED CONSENT FORM

The therapies offered by Catherine Brown Practitioner of Traditional Chinese Medicine have a long history of safe practice, however here are some risks associated with any sort of treatment. Below is a list of potential risks associated with the Traditional Chinese Medicine therapies. All treatments will be explained to you before commencement. The best way to reduce the chance or risk is to answer all questions about your health fully and honesty, if you require further information or have specific questions please ask.

Outline of possible risk	**Therapy**	**Strategies to minimise possible risk**
Pain	Acupuncture Cupping Electro-Acupuncture	Tell your practitioner if you have sensitive skin and become uncomfortable or experience pain during treatment.
Bruising	Acupuncture Cupping Electro-Acupuncture	Tell your practitioner if you bruise easily or have a bleeding disorder. Cupping may leave bruises that are usually painless and may last over a week. It is important to tell the practitioner if bruises in the area being cupped are cosmetically unacceptable.
Infection	Acupuncture Cupping	It is possible to develop an infection whenever the skin is punctured so please inform the practitioner if you have a known immune deficiency so special precautions can be taken. Pre-sterilised single use needles are used in this clinic.
Burn	Moxibustion Heat lamp	Please advise the practitioner if you have sensitive skin and if heat used during treatment is uncomfortable.
Relaxed or Sleepy	Acupuncture Cupping Moxibustion	It is common to feel relaxed or sleepy after treatment therefore avoid getting up quickly from the treatment table and give yourself time to adjust after the treatment before driving or using stairs. Avoid driving immediately if you feel sleepy.
Drug Herb Interactions	Herbal Medicine	It is important to tell the practitioner about all medications and herbal or nutritional supplements that you are currently taking or have recently stopped taking, as interactions between herbal medicine & Western medicine are possible. Chinese herbal medicine & supplements prescribed are considered safe although some maybe toxic in large doses or inappropriate

		during pregnancy.
Fainting	Acupuncture Cupping Massage	Do not skip a meal before treatment. Get up slowly after the treatment
Aggravation of your condition	Any therapy	It is possible that your condition could be aggravated. This is uncommon but can occur.

Please notify the Practitioner if you have an INFECTIOUS DISEASE, are a HAEMOPHILIAC, have an existing HEART CONDITION, PACEMAKER, are on BLODD THINING MEDICIATION, are PREGNANT, suffer form EPILEPSY or have suffered SEIZURES.

Please be aware that the above information is required in order for this practice to provide you with appropriate health care services. Failure to disclose any information regarding your health may affect the practitioner's ability to deliver these services you safely.

I confirm I have read and understand the risks outlined above are possible and agree to undergo treatment of Traditional Chinese Medicine from this clinic.

PRIVACY POLICY

I understand the practitioner may review my medical records and lab reports and that all my records will be kept secure & confidential and will not be released without my written consent.

Signed: ______________________________

Date: ______________________________