Purple Tree Healing Centre

4103-325 McIntosh Rd St., Kelowna BC V1X-2C6 - Tel: 250-448-4461 - Email: laynah@shaw.ca - Website: www.purpletreehealingcentre.com

火 木 土 水 金

Confidential Health Inventory

NOTE
This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete the questionnaire as thoroughly as possible. Thank you.

Name: ______________________________ Age: ________ Today's Date: ______________
LAST FIRST (MM/DD/YYYY)

Address: ____________________________ City: ____________ Prov: ____ Zip: _________

Mailing Address (if Different): ____

Home Phone: _________________________ Work Phone: _________________________

Fax # : _______________ Call Before Faxing E-mail: ______________________________

DOB: (dd/mm/yy): ____________________ Time of Birth: __________AM/PM
Place of Birth: _________________________

Employment Status: ☐Full-time ☐ Part-time ☐ School ☐ Retired ☐ Unemployed ☐ Other

Occupation: ____

Doctor's Name: _______________________ Doctor's Phone:_______________________

Gender: [ ] Female [ ] Male

Is this the same gender you were born?
[ ] Yes [ ] No

Posture assume most during day : ____

"*Health is a state of complete harmony of the body, mind and spirit. When one is free from physical disabilities and mental distractions, the gates of the soul open.*" ~B.K.S. Iyengar

I. Goals: What are the major health concerns that have brought you to this office today?

____

____

____

When did this condition begin?

____

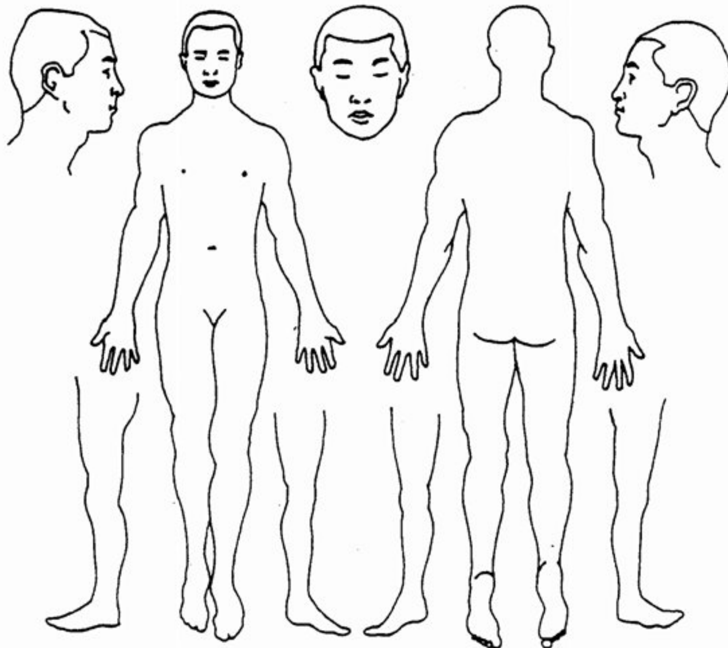
____

Has anything recently changed or become worse?

____

____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? [ ] Yes [ ] No

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing

P P P Pins & Needles

D D D Dull/Aching

N N N Numbness

On a scale of 1-10 (10 being worse)

How would you rate your pain intensity?

____

What would you consider the worst pain for you?

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.

(Most concerning to least, along with the duration of the symptom)

1. ____
2. ____
3. ____

PERSONAL HEALTH HABITS

Height:________________ Current Weight:___________ Weight 1 year ago: __________

Are you a smoker: Yes / No How many years? __________ How many per day? _________

Do you drink alcohol? Yes / No What kind? _______________ Frequency? ________________

Do you use recreational drugs? Yes / No What kind? ________________ Frequency? ________________

Do you drink coffee? Yes / No How much? _______________ Frequency? ________________

Do you Exercise? Yes / No Frequency? ________________ Duration? _________________

Type? ____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? [ ] Yes [ ] No

If yes, what was it? ____

If so, please list which and when you first noticed symptoms?

____

Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

If yes which and when? ______________________________

In the past year, how many days have been significantly affected by your health? __________

How many days did you feel generally poor? ______________________________

How many times were you in the hospital? ______________________________

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

____

____

"The wise nourish life by flowing with the four seasons and adapting to cold or heat, by harmonizing joy and anger in a tranquil dwelling, by balancing yin and yang, and what is hard and soft. So it is that dissolute evil cannot reach the man of wisdom, and he will be witness to a long life."

-Huang di Nei jing

CURRENT/RECENT HEALTH CARE PROVIDERS

Name	Dates	Care Provided

III. Medical History

Please check all that apply	***Date Diagnosed***		***Date Diagnosed***
Diabetes I or II	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	Low Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures/Epilepsy	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Chlamydia	___ / ___ / ___
Herpes	___ / ___ / ___		

Any other not mentioned above that we should know about?

____

____

____

____

IV. Family History (Please, check all that applies and state how you are related to the family member with that condition.)

Condition	**Mom**	**Dad**	**Sib(s)**	**Mom's sib(s)**	**Dad's sib(s)**	***MGM**	***MGF**	***PGM**	***PGF**	**Aunt/ Uncle**
Allergies										
Asthma										
Cancer										
Circulatory										
Depression										
Diabetes										
Glaucoma										
Heart disease										
Hypertension										
Migraines/Headaches										
Miscellaneous										
Obesity										
Osteoporosis										
Other mental illness										
Pelvic Disorders										
Stroke										
Substance abuse										

* M = Maternal P = Paternal GM = Grandmother GF = Grandfather

V. HOSPITALIZATIONS/SURGERY (include here, breast reduction/implants, caesarean birthing, scarring, tubectomy, circumcision, body piercing etc.)

Date	Hospital	Diagnosis/Operation	Doctor

VI. Medications / Supplements / any inorganic stuff

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

Medication Name	What it's for	For how long?	Strength	Dose	Frequency

Supplement/Herb name	Brand Name	Potency (mg, IU etc)	Dose	Frequency

ALLERGIES (to medications, environment, chemicals or foods, drug allergies (penicillin, etc.) :

____

____

____

ACCIDENTS / INJURIES (Briefly describe)

MORE than 5 years ago:________________________________

____

LESS than 5 years ago:________________________________

____

VII CANCER INFORMATION

Have you ever been diagnosed with cancer, a mass or tumor? Yes / No

When? ________________________ Location: ____

Type? ________________________ Current Status _______________ Stage ________________________

Type? ________________________ Current Status _______________ Stage ________________________

Current tumor markers ____

Date **Chemotherapy/Radiation/Other** **Dose** **Frequency** **Duration**

____

____

____

If you are in a clinical trial or experimental protocol please provide details.

____

____

____

PLEASE RATE THE FOLLOWING ON A SCALE OF 1 TO 10: (10 BEING THE BEST) – & WRITE IN ANY COMMENTS

Sleep

____

____

Energy Level

____

____

Appetite

____

____

Digestion

____

____

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No ---- If yes, how would you describe the diet? (*I.e. Vegetarian, Vegan, Low Carb, Gluten free, etc*)

____

2. What do you eat on a "typical" day?

____

a) Breakfast

____

b) Lunch

____

c) Dinner

____

d) Snacks

____

e) Foods you tend to crave:

____

f) Foods you dislike:

____

g) How much water do you drink per day

____

*** Sample of day's menu (Please also fill out 3-day food chart if you have been asked to do so)

IX. FOR WOMEN ONLY!

MENSTRUAL PERIODS

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment.

Since age_______ Length of cycle__________ Flow lasts how many days? _______

Light __________ Heavy___________ Clots? _______ Color of blood___________

Menstrual cramps? ________________ Which Days? ________________________

DATE OF LAST MENSES______________ PMS? _____________________________

Describe symptoms

____

____

____

____

HISTORY

Mark the following: 1 if current, 2 if past

-- hysterectomy
-- irregular PAP smear
-- tubal ligation
-- fibroids
-- herpes
-- ablation
-- D&C
-- interstitial cystitis
-- irregular bleeding
-- pain w/ intercourse
-- infertility
-- dryness w/ intercourse
-- breast cancer
-- mastectomy
-- lumpectomy
-- yeast infections

Vaginal Discharge? [ ] Yes [ ] No **Color** _________ **Frequency** ________ **Amount** _________

Do you have breast implants? [ ] Yes [ ] No

If yes, any problems noted with these? ____

PREGNANCY / BIRTH CONTROL

Are you pregnant now? [ ] Yes [ ] No Do you think you may be? [ ] Yes [ ] No

Number of pregnancies ____________________ Number of children _________________________

Terminations? ___________________________ Miscarriages? ______________________________

Tubular pregnancies? ______________________ Difficulty in conceiving? ____________________

Birth control method(s) ____

MENOPAUSE

No menses since ____

Experiences/symptoms you are currently feeling/having?

____

____

____

____

Experiences/symptoms you had in the past during menopause?

____

____

____

____

X. FOR MEN ONLY!

Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe please:

____

____

Check all that apply:

Erectile dysfunction	Difficulty w/ orgasm	Pain/ subtly of testicles
Frequent need to urinate at night	Enlarged prostate	Pain or swelling of the testicles
Premature ejaculation	Feeling of coldness or numbness in genitalia	Impotence

Do you get up at night to urinate? [ ] Yes [ ] No ------ If Yes, How often? ______________

To what extend do these conditions interfere w/ your daily activities (work, sleep, socializing, sex, etc.)?

____

____

Have you sough Medical Intervention for these problems? [ ] Yes [ ] No

When? ____________________

What treatments have you tried for these problems and how successful have they been?

____

____

Have we miss anything else, please describe here?

____

____

HEALTH CONCERNS

Please check if you have experienced any of these **in the last 3 months**.

Skin & Hair

Rashes	Eczema	Recent moles
Poor healing sores	Psoriasis	Change in texture
Hives	Pimples	Dry Scalp, & hair
Itching	Dandruff	Tumors, lumps
Rosacea	Loss of hair	

Any other problems with skin, nails or hair?

____

____

Head & Neck

Dizziness	Enlarge lymph glands	Migraines
Fainting	Headaches	Concussions
Neck stiffness		

Any other problems with the Head & Neck?

____

____

Eyes, Ears, Nose & Throat

Cataracts	Glasses/contacts	Sinus congestion
Glaucoma	Ringing in the ears	Sinus infections
Eye pain	Ear infections	Difficulty swallowing
Eye inflammation	Decreased hearing	Mucous in throat
Spots in front of eyes	Sore throats	Swollen glands
Earaches	Canker sores	Frequent colds
Poor hearing	Cold sores	Hay fever
Blurred vision	Grinding teeth	Allergies
Visual changes	Nose bleeds	Loss of smell
Poor night vision	Clicking jaw	
Floaters	Facial pain, neuralgia	

Any other problems with the Eyes, Ears, Nose & Throat?

____

____

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Heart & Circulation

High blood pressure	Fainting	Blood clots
Low blood pressure	Cold hands & feet	Palpitations
Chest pain	Phlebitis	Varicose veins
Irregular heart beat	Easy bruising	Difficulty breathing

Any other problems with the Heart & Circulation?

____

____

Breathing & Respiration

Cough	Coughing blood	Pneumonia
Bronchitis	Frequent colds	Pain on breathing
Asthma	COPD	Shortness of breath

Difficulty breathing when lying down? ______________________________

Any other problems with the Breathing & Respiration?

____

____

Digestion

Food cravings	Abdominal pain	Mucous in stools
Poor appetite	Indigestion	Rectal pain
Bad breath	Heartburn	Hemorrhoids
Difficulty swallowing	Gas	Diarrhea
Nausea	Bloating	Constipation
Vomiting	Blood in stools	Black stools

Number of bowel movements per day ____________

Loose	Normal	Hard

Any other problems with the Digestion?

____

____

STOOLS

Float	Daily	No odor
Sink	Bad odor	Pale stools

Do you rely on any of the following elimination?

Enemas

Laxatives

Purgatives

What type/brand? ___________________________ How often? _______________________________

Any other problems with the Stools?

____

____

Urinary

Pain on urination

Frequent urination

Blood in urine

Urgency of urination

Kidney stones

Irregular flow

Gout

Inability to hold urine

Decrease in urine flow

Difficulty starting or stopping the flow of urine

Any other problems with the Urinary?

____

____

Musculoskeletal

Neck pain

Muscle pain

Stiffness of neck or shoulders

Back pain

Muscle weakness

Low back pain

Muscle spasm, twitching, cramps

Sore, cold or weak knees and/or back

Joint pain, 1 knee or both

Reduced range of movement

Chiropractic or Massage therapy _________________________ Frequency________________________

Any other problems with the Musculoskeletal?

____

____

"The doctor of the future will give no medicine, but will interest his patients in the care of human body, in diet and in the cause and prevention of disease." -Thomas Edison

Neuropsychological

Poor sleep
Poor memory
Numbness
Depression
Irritability
Anxiety
Seizures
High stress levels
Migraine
Headaches
Difficulty concentrating
Foggy or spacy feeling
Lack of coordination
Loss of balance

Hours of sleep per 24 hours ________________________ Naps? ___________________________

Stress management techniques?

____

____

Any other neurological or mental health problems?

____

____

General

Poor appetite
Excessive appetite
Change in appetite
Insomnia
Fatigue
Fevers
Chills
Night sweats
Sweats easily
Excessive thirst
Localized weakness
Poor coordination
Bleed & Bruise easily
Catch cold easily
Sudden energy drops
Slow metabolism (easy weight gain)
Intolerance to hear or cold

Any other health concerns?

____

____

Have we miss anything?

____

____

____

____

"Health is your most precious economy and sets the stage for how long you live in this world. Thank you so much for filling it to the best of your ability. I look forward to assisting you bridge your body's language via your pains."

-Laynah H. Lafond

INFORMED CONSENT to CARE AND TREATMENT

I understand that these treatments are all safe, natural methods of healing and I recognize the potential risks and benefits of these procedures as described below.

POTENTIAL BENEFITS:

Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of your main complaint(s).

Initials: _______

POTENTIAL RISKS:

Acupuncture - Although uncommon, there is a potential for acupuncture to cause temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needle site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage or possibly the aggravation of symptoms existing prior to treatment. Infection is a slight possibility even though our clinic uses only sterile disposable needles and maintains a clean and safe environment.

Initials: _______

Moxibustion - Burning of moxa (a Chinese herb – Mugwort) on or near the body has the potential risk of burns, blistering or scarring. **Initials: _______**

Herbal Medicine - Some possible side effects of herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my practitioner as soon as I experience any discomfort or adverse reactions. Large doses taken without my practitioner's approval may be toxic and some herbs may be inappropriate during pregnancy. **Initials: _______**

PREGNANCY:

Acupressure/Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points or herbs that could induce premature labor or miscarriage. **Initials: _______**

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CANCELLATION AGREEMENT AND WAIVER OF LIABILITY:

CONSULTANT HERBALIST: LAYNAH H. LAFOND, MEDICAL HERBALIST

I, the undersigned, hereby confirm that I understand that the above named individual is not a medical doctor nor is she licensed to practice allopathic medicine. I affirm that I am consulting with this practitioner for educational purposes, of my own free will. I understand that there will be no diagnosis made, nor prescription given, but that the practitioner will offer an assessment of my general state of health and will make dietary and herbal recommendations.

I agree to the cancellation policy of this clinic:

Full fee will be charged for missed appointments and for appointments cancelled with less than **two (2) working days'** notice. **Initials: _______**

Signature ___________________________________ Date ____________________________

CLINICAL RESEARCH

For the purposes of research and continuing education, it is occasionally helpful for practitioners to review case files and to discuss cases with colleagues, or to publish specific information in professional journals where there are important lessons to be learned from a case. I would like to ask your permission to potentially use selected information from this file for such purposes. At all times identifying features will be kept private and no confidential information will be divulged. This is strictly for the purposes of learning and teaching.

Please indicate below if you give permission for such research use: ***Initials beside your choice***

____ I give my permission for selected information in this file to be used for continuing learning purposes.

____ I do not give my permission for selected information in this file to be used for continuing learning purposes. **Initials: _______**

PRIVACY:

I understand that my information is held is strict confidence and will not be shared with anyone unless given written permission by myself. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_________________	_________________	_________________
Print Patient's Name	Patient's Signature	Date