



TerraSana Health

26, 7337 Sierra Morena Blvd. SW Calgary AB, T3H 3V4
Phone: 403-686-2971 Fax: 403-686-3971 Website: www.terasana.ca

Patient Information

Confidential

Name (Last, First, Middle)	Date
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Age	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Phone:	Cell:
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Email Address

Home Address

City	Province	Postal Code
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Occupation

Spouses Name

Contact in Case of Emergency	Relationship	Phone
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Additional Information/Notes

<p>Waiver</p> <p>I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by TerraSana Health is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.</p> <p>_____ Signature</p> <p>_____ Date</p> <p>Signature of Parent or Guardian if Patient under 18 years of age _____</p>
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Medical History

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Name (Last, First, Middle)	Date
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Major Complaint/Health Problem

.....

.....

How Did This Condition Develop?

.....

.....

How Long Has This Condition Persisted?

Is there anything that makes it better?

Is there anything that makes it worse?

Have you ever received Treatment for this condition <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, When?
Where?	By Whom?
What was the diagnosis?	What kinds of treatment?
What were the results of the treatment?	
List any substances that you are Allergic to:	

List any Medications that you are currently taking:			
Medication	Strength	How Many Per Day	For How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Any Major Surgeries You Have Had:	
Date	Problem/Surgery
_____	_____
_____	_____
_____	_____

Significant Trauma (Auto Accidents, Falls Etc)



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Significant Illnesses (Please Check All That Apply)			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	

Please check any symptoms you currently have or have had in the past year.

General

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

Head & Neck

- Blurred Vision
- Heaviness in the head
- Phlegm in throat
- Cataract
- Double Vision
- Earache
- Ear discharge
- Eye pain/strain
- Corrected vision
- Nasal obstruction
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in the ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems
- Vision- see halos

Respiratory

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production

- Difficulty inhaling
- Difficulty exhaling

Cardiovascular

- Chest Pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

Diet/Lifestyle

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eat lots of sweets
- Take melatonin
- Take Steroids
- Exercise regularly
- Exercise excessively

Weight

- Underweight
- Normal for height
- Overweight
- Very overweight

Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning sensation
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Musculoskeletal

- Pain, weakness, numbness in:
- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

Skin

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry brittle hair
- Hair falling out

Neurologic

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures

- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

Emotional

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing

Men Only

- Genital pain
- Impotence
- Genital sores
- Lump in testicles
- Penis discharge
- Nocturnal emission
- Low Sexual energy

Women Only

- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy periods
- < 25 day cycle
- >35 day cycle
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitalia
- Low sexual energy
- Vaginal discharges
- Menopausal
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant



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Waiver

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status. I agree to immediately inform the doctor if I experience any pain or discomfort during my treatment. I assume all risks and responsibilities for myself and release TerraSana Health, its directors, and the independent practitioner consulted, from responsibility from any injury or liability that may occur as a result of this session.

Signature

Date

Signature of Parent or Guardian if patient under 18 years of age _____



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Women's Fertility History *Continued*

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What type? _____

How is your sexual energy? Low Normal High

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

Have you taken medication to help you ovulate? Yes No

When _____ How long? _____

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Have your fallopian tubes been evaluated medically?
 Yes No

What were the results? _____

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Have you had any tubal operations? Yes No

Do you have excessive facial hair? Yes No

Have you had any hormone laboratory tests performed?
 Yes No

What were the results? _____

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

Do you have a single partner

With whom you have been trying to conceive? Yes No

How long have you been married or living together? _____

Was your mother exposed to Diethylstilbestrol (DES) when she was pregnant with you? Yes No

Has he had a fertility workup? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

What were the results? _____

Are you presently taking steroids? Yes No

Is your partner supportive of your wish to conceive?
 Yes No

Have you taken oral contraceptives? Yes No

When _____ How long? _____

Have you ever had an IUD? Yes No

When _____ How long? _____

Have you ever taken DepoProvera? Yes No

When _____ How long? _____

How long have you been trying to conceive? _____

Have you had a diagnoses relating to infertility? Yes No

What was it? _____

Comments/Notes