



522-30th Ave NE, Calgary, AB. T2E 2E3

P: 403-686-2971 F: 403-686-3971 E: info@terrasana.ca W: www.terrasana.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

Waiver

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.

Signature

Date

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



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Medical History

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

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.....

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?
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Where?	By Whom?
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What was the diagnosis?	What kinds of treatment?
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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)

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 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 _____

Appointment Policy

Welcome to TerraSana Health. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability.

24 hours notice for cancelled or rescheduled appointments is necessary in order to avoid a cancellation fee of \$80 + tax.

This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Please note that your credit card will be charged for appointments missed without adequate notice.

Credit Card# _____ Expiration Date _____

Please Circle VISA MC

3 digit security code on back of card _____

Name on Card (if different from above) _____

***Any questions regarding my appointments have been addressed.
I have read this statement and fully understand it.***

Signature

Date