



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 |
|----------------------------|------|

| | | | |
|-----|---------------|--|--|
| 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 |
|-----|---------------|--|--|

| | |
|--------|-------|
| Phone: | Cell: |
|--------|-------|

| |
|---------------|
| Email Address |
|---------------|

| |
|--------------|
| Home Address |
|--------------|

| | | |
|------|----------|-------------|
| City | Province | Postal Code |
|------|----------|-------------|

| |
|------------|
| Occupation |
|------------|

| |
|--------------|
| Spouses Name |
|--------------|

| | | |
|------------------------------|--------------|-------|
| Contact in Case of Emergency | Relationship | Phone |
|------------------------------|--------------|-------|

| |
|------------------------------|
| 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 under 18 years of age _____



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Medical History

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| | |
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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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Men's Fertility History

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| | |
|----------------------------|------|
| Name (Last, First, Middle) | Date |
|----------------------------|------|

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

How would you define your sexual energy? Below normal Normal

| | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|
| Do you have an undescended testes? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with a varicocele? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any urologic surgeries? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you experienced difficulty maintaining erection?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you experienced difficulty ejaculating? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had exposure to any known environmental toxins or hormones?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you experienced any penile discharge?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly experience nocturnal emission?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a fertility workup?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, what was your sperm count? Below normal Normal Number _____

What was the sperm motility? Below normal Normal Notes _____

What was the sperm morphology? Abnormal Normal Notes _____

Comments/Notes