# WELCOME PACKAGE

**Hello and welcome!**

The following is a package that walks you through your first session with Dr. Yuka Shimizu DTCM. RAc. RMT. BSc.
It includes information, consent forms, and intake forms for treatments.

Please print and fill out the forms. You can save paper by just printing off page 4 – 11 for a total of eight pages. Due to the private nature of the information in the filled forms, please do not send the forms via email or fax. You can bring them in on your first visit or come in 15 – 20 minutes early and fill out the forms there.

Seems a little bit epic but I promise that after this first session you will not be required to do another daunting task like this.

Please contact me for any questions.

yuka4health@hotmail.com
www.acupunctureincanmore.ca

Active Edge Chiropractic
208 -1240 Railway Ave
Canmore. AB. T1W 1P4
(403) 678 - 1240

## WHAT TO EXPECT

A few house keeping points:

Please be advised that we require 24 hours notice for any cancellations. Cancellations within 24 hours of your appointment time will be charged the full fee, unless the reason for cancellation is an emergency or the appointment time can be filled by another client.

For your appointment arrive a few minutes early or on time, as you will be charged the full appointment time even if the time is not spent for treatment.

On the day of your first appointment:

Make sure that you have eaten and are well hydrated before the session.

Wear comfortable clothes and bring water and a snack if you think you may be hungry after the consult, which take approximately 60 – 90 min. If you have an iPod and would like to listen to your own selection of music, please bring this with you, otherwise I have a wide selection you can choose from.

Consult:

I will ask you a range of questions starting with your main concern. From the information you have provided in the forms as well as from the consult a diagnosis based in Traditional Chinese Medicine will be made. I will explain what the diagnosis is and why I came to that conclusion. (If the consult takes more time than what is scheduled, we will book you in for the next available slot and that treatment will be of no charge).

Treatment:

The consult will be followed by the treatment which can take anywhere from 30 – 60 min. With acupuncture the needles will be left for 15 – 30 min. During this time I will leave the room and allow you to relax in peace. For our first meeting I will check in on you after 10 min to assure you are feeling comfortable.

Other Traditional Chinese Medicine treatments include Chinese herbs, Tui Na massage, cupping, moxibustion, heat therapy, electric stimulation, auricular medicine, and or TCM diet therapy.

*These are explained at www.acupunctureincanmore.ca.

Based on your diagnosis and what I feel will be most effective we will devise a treatment plan with one or more of the methods mentioned above.

Once the treatment is over, we will discuss when and what you should be booking for the next session. I encourage you to hydrate and take it easy for the rest of the day.

Follow–up:
With your permission I will be calling you after two days to see how you are feeling.

Treatment Course:
Acute (recent), and or musculoskeletal related concerns, usually take a couple of treatments per week for a short period of time.

Chronic concerns usually take one treatment per week and takes longer periods of time. Each individual is different so we will discuss your treatment course before you leave the first session.

For prevention or maintenance of health, every two weeks or once a month (dependant on your level of activity) visits are sufficient.

Other special treatments such as performance enhancing, fertility, and weight loss will have different and specific treatment courses to fit your needs.

Questions or concerns are encouraged to be voiced at anytime during or outside of the visit. You can also call me at the clinic 403.678.1240 or send me an email (yuka4health@hotmail.com) and I will get back to you as soon as I can.

# Traditional Chinese Medicine Consult Form

## Dr. Yuka Shimizu

**Active Edge Chiropractic**
**208 - 1240 Railway Ave Canmore AB T1W 1P4**

**Name:**_____ **Date:**_____

**Date Of Birth (MM/DD/YY):**_____ **Gender: M / F**

**Address:**_____

**City:**_____ **Province:**_____ **Postal Code:**_____

**Home Phone:**_____ **Cell Phone:**_____ **Work Phone:**_____

**E-mail:**_____

**Occupation:**_____

**Primary Physician:**_____ **Phone #:**_____

**Emergency Contact:**_____ **Phone #:**_____

**How Did You Hear About Yuka:**_____

## General Medical Information

**Main Concern:**_____
_____
_____
_____
_____
_____
_____

**History of Concern:**_____
_____
_____
_____
_____
_____
_____

**NAME**_____ **DATE**_____

**I. Goals:** What would you most like to achieve through your work with Dr. Yuka?

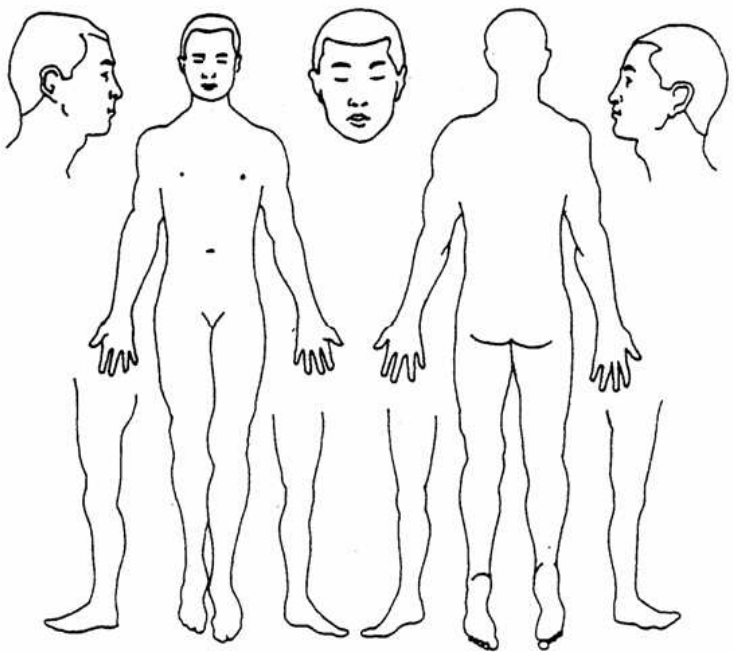
1. _____
2. _____
3. _____

**II. Major Symptoms:** Please list in order of importance what symptoms are of concern to you along with the duration you have been experiencing the symptom for.

1. _____
2. _____
3. _____
4. _____
5. _____

**Use the following illustration to indicate painful or distressed areas:**

If you are experiencing pain/discomfort circle the location using the models below and use the space around the models to describe your pain / discomfort.



**III. Medical History**

**Please circle all that apply and indicate the date of diagnosis.**

| | **Date Diagnosed** | | **Date Diagnosed** |
|---|---|---|---|
| Diabetes | ____ / ____ / ____ | High Cholesterol | ____ / ____ / ____ |
| High Blood Pressure | ____ / ____ / ____ | Blood Disorder | ____ / ____ / ____ |
| Thyroid Disease | ____ / ____ / ____ | Seizures | ____ / ____ / ____ |
| Cancer | ____ / ____ / ____ | Hepatitis | ____ / ____ / ____ |
| HIV | ____ / ____ / ____ | Heart Disease | ____ / ____ / ____ |
| Other_____ | ____ / ____ / ____ | Other_____ | ____ / ____ / ____ |

**IV. Surgical History**

_____ Date _____

_____ Date _____

_____ Date _____

**V. Family History**

Please check all that apply and place the check in the column of the member affected.

| Condition | Mother | Father | Sibling | Maternal Grandparent | Paternal Grandparent |
|---|---|---|---|---|---|
| Heart disease | | | | | |
| Cancer | | | | | |
| Hypertension | | | | | |
| Stroke | | | | | |
| Allergies | | | | | |
| Depression | | | | | |
| Mental Illness | | | | | |
| Substance abuse | | | | | |
| Osteoporosis | | | | | |
| Diabetes | | | | | |
| Glaucoma | | | | | |

**VI. Medications / Supplements**

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 if known)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (to medications, chemicals or foods):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

**VIII. Nutrition**

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet? (ie Vegetarian, Vegan, Low Carb, 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: _____

**IX. Social History**

1. How much per day do you use of the following?
   a) Coffee, tea, soft drinks: _____
   b) Alcohol: _____
   c) Cigarettes, cigars, other tobacco: _____
   d) Other drugs: _____
2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No
3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No
4. If yes which and when? _____
5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No
6. If so, please list which and when you first noticed symptoms?

   _____

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

   _____
8. How many days did you feel generally poor? _____
9. How many times were you in the hospital and why? _____
10. Please describe your current exercise regimen:

    Hours per week: _____ Activities: _____ [ ] No Exercise

**X. Other Information**

Please list and briefly describe the most significant events in your life:

1. _____
2. _____
3. _____
4. _____

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 concerns? [ ] Yes [ ] No

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

_____

_____

_____

_____

_____

_____

Yuka Shimizu DTCM. RAc. RMT. BSc.

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# PATIENT CONSENT FORM FOR ACUPUNCTURE AND TRADITIONAL CHINESE MEDICAL TREATMENT

I, _____ (print name), hereby fully understand the acupuncture treatment process and the possible side effect such as:

- fainting
- small bruises
- post - acupuncture sensation (numbness, tingling, heaviness, and tiredness)
- temporary exacerbation of symptoms

I agree to fully disclose all past and current health conditions.

I also give consent to have acupuncture and all treatments included in Traditional Chinese Medicine such as Chinese Herbs, Tui Na massage, cupping, moxibustion, TDP lamp, electric stimulation, auricular therapy, and TCM diet therapy from Dr. Yuka Shimizu.

| | |
|---|---|
| Patient Signature | Date |
| Witness Signature | Date |
| Parent/Guardian Signature | Date |

Yuka Shimizu DTCM. RAc. RMT. BSc.

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# PATIENT CONFIRMATION OF CONSULTATION WITH PRIMARY PHYSICIAN

Alberta acupuncture legislation states that an acupuncturist must not treat someone who has not consulted with a primary care physician or, in the case of dental pathology, a dentist about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable box confirming that you already have seen a physician, or will be seeing one within two weeks of your first acupuncture treatment.

- ☐ I have already seen a primary care physician (Western Medical Doctor) regarding the condition(s) that I am seeking treatment for.

- ☐ I agree to see a doctor regarding the condition(s) that I am seeking treatment for within two weeks of my first acupuncture treatment at Active Edge Chiropractic.

| | |
|---|---|
| Patient Signature | Date |
| Witness Signature | Date |
| Parent/Guardian Signature | Date |

# ACTIVE EDGE CHIROPRACTIC
# PROTECTS YOUR HEALTH INFORMATION AND PRIVACY

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, Worker's Compensation, employer, or with other medical practitioners.

We will obtain your authorization before disclosing any information.

**Safeguards in place at our office include:**

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

**Types of information that we gather and use:**

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship with you, and respect your right to privacy. If you have questions about our privacy guidelines please ask Yuka.

Yours in health and wellness,

Yuka Shimizu DTCM. RAc. RMT. BSc.

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# THANK YOU!!

Thank you for taking the time and effort to fill these forms out. By filling these forms in detail I am able to see the whole picture of the state of your health which allows for proper diagnosis and treatment.

I look forward to meeting you in person!

Have a wonderful day!!

**Yours in health and wellness,**

**Yuka Shimizu**