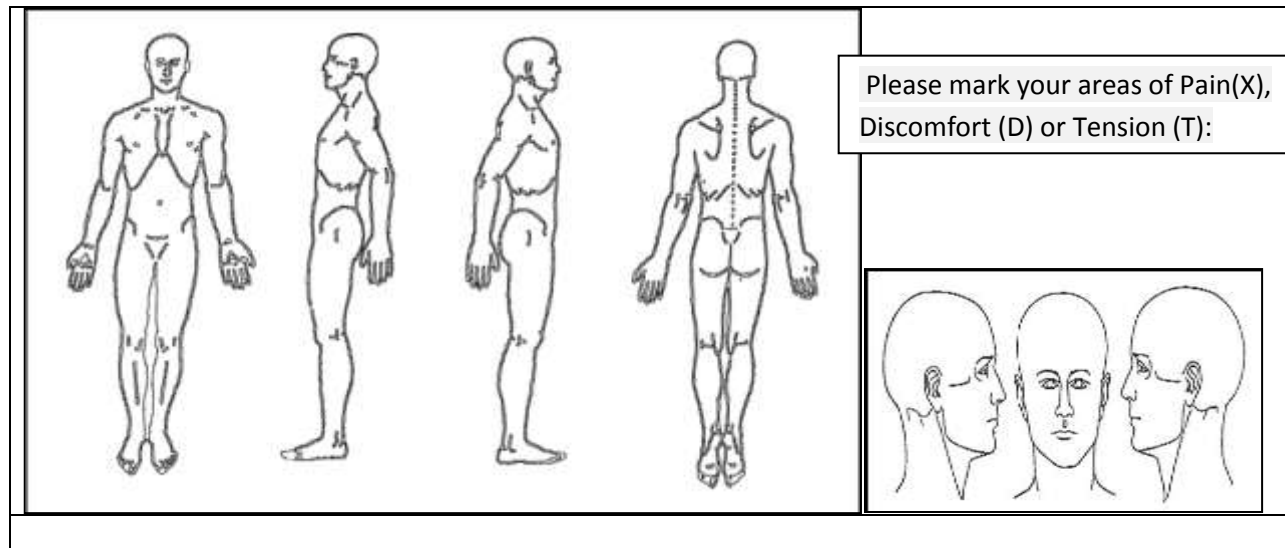




## Acupuncture Patient Intake Form

| Patient Information  |                    |                   |                      |
|--|--------------------|-------------------|----------------------|
| Last Name:   | First Name:        | Sex M / F         |                      |
| Home Address ( City, Province, Postal Code)  |                    | Date of Birth:    |                      |
| Phone:   | Email:             | Occupation:       |                      |
| Emergency Contact Name:  |                    | Email:            | Phone:               |
| Please describe your main concerns:  |                    |                   |                      |
| 1.   |                    |                   |                      |
| 2.   |                    |                   |                      |
| 3.   |                    |                   |                      |
| <b>Do you have any of the following infectious diseases? (Please circle):</b>  |                    |                   |                      |
| Hepatitis Type (A, B, C, D), HIV Positive, Tuberculosis, Herpes (Oral, Genital), Any STD's? Other?<br>Do you have any Infectious skin conditions; where? |                    |                   |                      |
| Past Surgeries or Medical Procedures:  |                    |                   |                      |
|  | Reason for surgery | When              | Location on the body |
| Surgery 1  |                    |                   |                      |
| Surgery 2  |                    |                   |                      |
| Surgery 3  |                    |                   |                      |
| Major Physical Trauma (Car Accident, Fall, Head Trauma, Etc):  |                    |                   |                      |
| Birth  |                    |                   |                      |
| Childhood  |                    |                   |                      |
| Adolescence  |                    |                   |                      |
| Adulthood  |                    |                   |                      |
| Are you currently taking any medications? (Y/N) Please list:   |                    |                   |                      |
|  | Name of Medication | Reason for taking | Since when           |
| Med 1  |                    |                   |                      |
| Med 2  |                    |                   |                      |
| Med 3  |                    |                   |                      |



**Personal History - Major Conditions**

|                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Chronic Fatigue  | <input type="checkbox"/> Lyme Disease      |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Pancreatitis               | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Reduced Immunity | <input type="checkbox"/> Chronic Pain      |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hypo/Hyperglycaemia        | <input type="checkbox"/> Fibromyalgia     | <input type="checkbox"/> Tumour            |

**Skin and Hair**

|                                     |  |                                      |   |
|-------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Rashes     | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Eczema/Psoriasis |
| <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Fungal Infection          |                                      |   |

**Head, Eyes, Ears, Nose and Throat**

|  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Difficulty swallowing       | <input type="checkbox"/> Eye pain         | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Recurrent sore throat/Colds | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Earaches        | <input type="checkbox"/> Spots in front of eyes      | <input type="checkbox"/> Blurred Vision   | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sores on lips/tongue        | <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Facial pain     |
| <input type="checkbox"/> Poor hearing    | <input type="checkbox"/> Dental problems             | <input type="checkbox"/> Grinding Teeth   | <input type="checkbox"/> TMJ             |

**Cardiovascular / Circulation**

|   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular Heart beat   | <input type="checkbox"/> Palpitations         | <input type="checkbox"/> Easy to faint |
| <input type="checkbox"/> Cold hands/Feet        | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood Clotting prob. | <input type="checkbox"/> DVT           |
| <input type="checkbox"/> Pressure in chest      | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Anemia        |

**Respiratory**

|   |   |                                     |                                    |
|---|---|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma         | Other:                                  |                                     |                                    |

**Gastrointestinal**

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chronic Diarrhoea | <input type="checkbox"/> Constipation     |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Gas      | <input type="checkbox"/> Food Intolerance  | <input type="checkbox"/> Acid reflux/GERD |
| <input type="checkbox"/> IBS/Crohn's    | Other:                            |  |   |

**Genito-Urinary**

|   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Frequent urination       | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Kidney stones  | <input type="checkbox"/> Urinary tract infections | Other:                                  |  |

### Gynecological / Reproductive

|   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Ovarian Cysts        | <input type="checkbox"/> Vaginal discharge      | <input type="checkbox"/> PMS                         | <input type="checkbox"/> Irregular menstruation    |
| <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Endometriosis          | <input type="checkbox"/> Uterine / Ovarian Fibroids  | <input type="checkbox"/> Fibrocystic breast tissue |
| <input type="checkbox"/> Abortions(When):     | <input type="checkbox"/> Pregnancies(How many): | <input type="checkbox"/> Caesarean births(How many): | <input type="checkbox"/> Infertility               |

Birth control?  Yes  No: \_\_\_\_\_ Since when? \_\_\_\_\_ Type: \_\_\_\_\_

### Psychological / Neurological

|  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Bad Temper/Irritability | <input type="checkbox"/> Areas of numbness            | <input type="checkbox"/> Vivid dreams        |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> ADD/ADHD                | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Waking up at night: |
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Vertigo/Dizziness       | <input type="checkbox"/> Seasonal Affective Disorder  | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Concussion              | <input type="checkbox"/> Poor Sleep                   | <input type="checkbox"/> Bi-Polar Disorder   |

Have you ever been treated for emotional problems?  Yes  No

Have you ever considered or attempted suicide?  Yes  No

Have you ever been treated for substance abuse?  Yes  No

Comments: Please inform us of any other problems you would like to discuss:

**I hereby declare that the information that I have given above regarding my health condition is accurate and true to the best of my knowledge.**

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Informed Consent to Treatment

**I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.**

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. **Additional treatment methods** can include, but are not limited to: acupuncture, acupressure, the Electrical stimulation of needles, Cupping or Moxibustion, Gua sha, and **Structural Techniques**. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. **I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis.** In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. *In some cases my symptoms may temporarily worsen before they begin to improve.*
6. *I am responsible for the full and prompt payment after services have been rendered.*
7. *I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.*

|               |            |       |
|---------------|------------|-------|
| Patient Name: | Signature: | Date: |
|---------------|------------|-------|