Acupuncture and Traditional Chinese Medicine Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Preferred Pronoun (he/him, she/her, they/them, etc.): _____

Name: _____ Date of First Visit:_____

Date of Birth: _____ M / F Occupation: _____

Address:_____Postal Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email Address_____ Preferred method of contact: Home Cell E-Mail

Family Doctor: _____Phone_____

Emergency Contact Name: _____Phone: _____

How did you hear of us?_____

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

_____

_____

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: _____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _____

_____

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it

_____

_____

_____

Females: Is are you currently pregnant? NO **YES Due Date: _____**

Do you have a contagious disease at this time? NO YES: _____

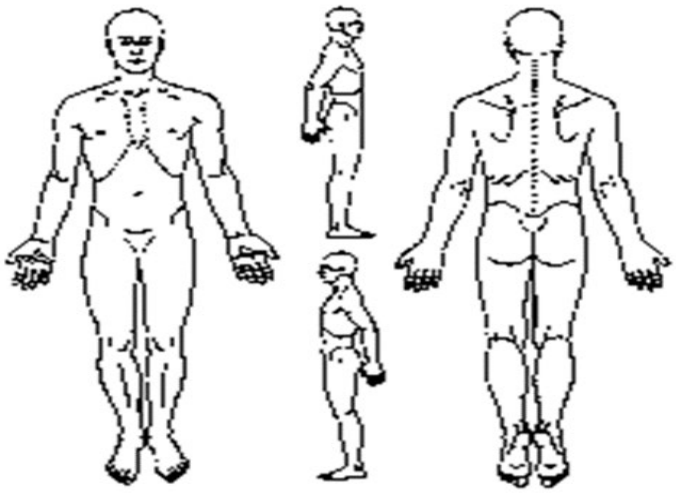
Do you have any of the following?

- O Pacemaker
- O Epilepsy
- O Surgical implants
- O Hemophilia
- O Fear of needles
- O Hepatitis _____
- O HIV
- O Tuberculosis
- O Latex allergy
- O Nut allergy
- O Other Allergy: _____

If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

Degree of pain (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain
O Constant
O Comes and goes
O Dull
O Burning
O Aching
O Spasm
O Numb



Does the pain get better, or worse with?
O Heat *better worse*
O Cold *better worse*
O Motion *better worse*
O Rest *better worse*
O Pressure *better worse*
O Better in *AM* or *PM*

General Health Questionnaire

How much do you consume per day of:
Water _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Cigarettes _____

What are your typical eating habits?
O Skip Meal(s)_____
O Eat When Not Hungry
O Craving specific food(s)_____
O Excess Hunger
O No Desire to Eat
O Cannot eat when Worried/Stressed

What are your typical sleeping habits?
O Hours slept/night _____
O Trouble falling asleep
O Trouble staying asleep
O Frequent dreaming
O Disturbing dreams
O Other _____
O Wake at same time every night _____

How would you describe your energy levels?
O High
O Low
O Normal
O Lethargic
O Hyperactive
O Changes from day to day

What is your Average Body Temperature?
O Hot
O Cold
O Cold Hands & Feet
O Hotter @ Night
O Colder @ night
O Hot Flashes
O Hot Joints

Musculoskeletal:
O Osteoarthritis
O Rheumatoid arthritis
O Body heaviness
O Broken Bones: _____
O Other: _____
O Joint pain
O Limited motion
O Muscle pain / cramps
O Scoliosis
O Weight gain
O Weight loss

Head, Eyes, Ears, Nose and Throat

- O Allergies / Hay Fever
- O Concussion _____
- O Dry mouth / nose
- O Ear aches
- O Excess phlegm in throat
- O TMJ Syndrome / Jaw Pain
- O Headaches / Migraines
- O Red, dry and/or itchy eyes
- O Spots in eyes
- O Sinus issues
- O Ringing in ears
  - o High pitch
  - o Low pitch
- O Other _____

Respiratory & Cardiovascular

- O Asthma
- O Frequent colds
- O Chronic cough
- O Emphysema or COPD
- O Heavy or tight chest feeling
- O Anemia
- O Easily bruised
- O Poor circulation
- O Blood clots
- O Fainting
- O High cholesterol
- O High blood pressure
- O Low blood pressure
- O Heart palpitations
- O Chest pain
- O Irregular heartbeat
- O Pacemaker
- O Phlebitis
- O Stroke
- O Heart Disease
- O Other: _____

Gastrointestinal

- O Normal Stool
- O Loose stool
- O Constipation
- O Diarrhea
- O Undigested food in stool
- O Heartburn/acid reflux
- O Abdominal pain
- O Bloating / Gas
- O Nausea /vomiting
- O Hernia
- O Liver Disorder
- O Ulcer
- O Other: _____

Urinary

- O Frequent Bladder infections
- O Frequent urination
- O Incontinence
- O Prostate Disorder
- O Kidney stones
- O Kidney Disease
- O Other: _____

Gynecological

- O Menopause
- O Breast lumps
- O Genital burning, itching, discharge or swelling
- O Hysterectomy
- O Endometriosis
- O Fibroids or cysts
- O PMS _____
- O Heavy Periods
- O Light periods
- O Irregular Periods
- O Other _____
- O Other_____
- O # Pregnancies _____
- O # Miscarriages_____

Days between periods _____ # days of period_____

Skin and Hair

- O Acne
- O Dermatitis
- O Eczema
- O Fungal infection
- O Heavy sweating
- O Not able to sweat
- O Hives
- O Itchy, Dry Skin
- O Psoriasis
- O Rashes
- O Shingles
- O Other_____

Neurological & Psychological

- O ADD / ADHD
- O Addition
- O Anxiety
- O Depression
- O Easily Stressed
- O Epilepsy / Seizure Disorder
- O irritability
- O Foggy headed feeling
- O Poor Coordination
- O Parkinson's Disease
- O Poor memory
- O Vertigo / Dizziness
- O Other: _____

Any other health concerns you would like to share? _____

Patient Consent to Treatment - Acupuncture and Associated TCM Modalities

1. I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment.

2. I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including, but not limited to: numbness or tingling, dizziness or fainting, minor swelling, bleeding or bruising. I will immediately notify the acupuncturist if I experience any symptoms or problems before, during or after treatment. I freely accept the risks involved with my procedure

3. I understand that I should not make significant controlled movements while the needles are being inserted, manipulated, retained, or removed as this may result in pain, a bent, suck or broken needle.

4. Additional treatment methods may include: the electrical stimulation of needles, cupping, gua-sha or acupressure. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
    a. I understand that if cupping or gua-sha treatments are used, that there will be marks left on the skin that look similar to bruises and may last for up to 1 week after treatment.

5. I will give my practitioner full and accurate information about my health during the initial consultation and continue to inform my practitioner if I develop any new health issues, including but not limited to: developing new allergies, infectious diseases, surgical interventions or if I become pregnant.

6. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, tuberculosis and Hepatitis. In some cases, where cross-infection is high, my practitioner may withhold treatment.

7. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not usually 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.

8. I understand that the fees charged for my treatment are not covered by provincial health insurance and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.

9. By signing this form, I give my informed consent for Acupuncture & Traditional Chinese Medicine. I realize I may withdrawal my consent at any time.

10. COVID 19: I confirm that I do not currently have any of the symptoms COVID 19. I have not tested positive for COVID 19 in the last 30 days. I am not awaiting the results of a COVID 19 test nor are any members of my household. I do not need to be self-isolating for any reason. I understand that the clinic and the staff are following proper protocols to reduce the spread of COVID 19. I release the clinic/practitioner from any legal claims should I become infected with COVID 19. I give permission to my practitioner to supply the Public Health Office with my name and contact information should it become necessary during Contact Tracing Procedures by the government. I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks association with receiving care during the COVID 19 Pandemic.

Patient Name (Printed)_____

Patient/Representative Signature _____ Date_____

For office use: I, Emily Burnie, BSc, RAc, confirm that I have discussed the above with the client during the initial intake and have given the client the opportunity to ask any questions.

Practitioner Signature _____ Date_____