Fort Saskatchewan ACUPUNCTURE

NEW PATIENT INTAKE FORM Appointment Date: _____

Please complete the following pages so we can best meet your healthcare needs. If you have any questions, please do not hesitate to ask.

Personal Information

Name:

_____ _____ _____
(First) (Middle) (Last)

Date of Birth: _____
(DD/MM/YYYY)

Occupation: _____ **Relationship Status:** _____

Address: _____

City: _____ **Province:** _____ **Postal code:** _____

Phone numbers: _____ _____ _____
(Home) (Cell) (Other)

_____ _____
(Work) (Ext)

Main Email: _____
(Used for appointment reminders and other information, if any)

Emergency Contact Details:

Name: _____ **Relationship:** _____

Phone Number: _____

Physician Name: _____ **Physician Number:** _____

How were you referred to us? _____

Reason(s) for visit (Please rank by priority)	**Onset** (i.e. June 2011)	**Frequency** (i.e. 4x/wk)	**Severity** (i.e. Scale: 5 out of 10) or mild/mod/severe
1.			
2.			
3.			

What are your goals for this visit?

_____

_____

Your past medical history:

Please include date/year of diagnosis. You may attach a separate list.
(i.e. Acid reflux – started 2003, had scope procedure Aug/2005, w/ normal result)

1. _____
2. _____
3. _____

Family medical history:
(please indicate type of disease)

1. _____
2. _____
3. _____

Surgeries:
(major/minor procedures – when, where)
1. _____
2. _____
3. _____

Injuries:
(i.e. Car accident in 1995 – head injury)
1. _____
2. _____
3. _____

Lifestyle habits:

Tobacco	☐ None	Smoked cigarettes age ___ to ___. ___ packs per week ☐ Chewing Tobacco
Alcohol	☐ None	Estimated drinks per week ___ Preferred drink(s) _____
Caffeine	☐ None	Estimated drinks per day ___ ☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Other: _____
Other Drugs	☐ None	Type(s) and frequency: _____

Medical history (please check all that apply)

☐ AIDS/HIV
☐ Alcoholism
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart disease
☐ Hepatitis __
☐ Hypertension
☐ Hypotension
☐ Measles
☐ MS
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Seizures
☐ Ischemic Stroke
☐ Hemorrhagic stroke
☐ Hyperthyroid
☐ Hypothyroid
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Whooping Cough
☐ Colitis
☐ Gastritis
☐ IBS
☐ Anemia
☐ Mononucleosis
☐ Bronchitis
☐ Osteo-arthritis
☐ Enteritis
☐ Rheumatoid arthritis

Allergic reactions/intolerances to medications:

_____
_____
_____

Allergic reactions/intolerances to foods, environment:

_____
_____
_____

Medications (prescription & OTC) (or attach your own list)	**Dosage & Frequency**	**Reason**	**Duration of consumption**	**Cost per month**

Herbal remedies and supplements Please include brand name (or attach your own list)	**Dosage & frequency**	**Reason**	**Duration of consumption**	**Cost per month**

What physical activities do you participate in and how often do you do so?

_____
_____

What do you do to relax?

_____
_____

What are the major stressors in your life?

_____
_____

How many servings of fruit do you usually eat/drink each day? _____
Serving = 1 small piece of fruit, ½ cup fruit juice, ½ cup canned or chopped fruit, ¼ cup dried fruit

How many servings of vegetables do you consume each day? _____
Serving = ½ cup raw or cooked vegetables, 1 cup fresh green leafy veg, ¼ cup dried veg or 1 small piece

How much water do you drink on a typical day? _____

How much caffeinated beverages (coffee/tea/etc.) do you drink in a day?

Coffee/Tea _____ per day Energy drink _____ per day Soda/Pop _____ per day

Please check boxes that are relevant to your dietary conditions:

☐ Poor appetite ☐ Normal appetite ☐ Excessive appetite
☐ Crave sweet ☐ Crave Salty
☐ Other Cravings _____
☐ Bitter taste in mouth ☐ Metallic taste in mouth ☐ Sweet taste in mouth ☐ Sour taste in mouth
☐ Other taste(s) in mouth _____
☐ No thirst ☐ Very thirsty ☐ Normal thirst

Please check the boxes that are relevant to your cardiovascular conditions:

☐ High blood pressure ☐ Lightheaded ☐ Fast heartbeat
☐ Palpitations ☐ Chest pain ☐ Orthostatic hypotension
☐ Fainting ☐ Slow heartbeat ☐ Low blood pressure
☐ Irregular heartbeat ☐ Phlebitis ☐ Heart attack

Please check the boxes that are relevant to your gastrointestinal conditions:

☐ Nausea ☐ Constipation ☐ Intestinal cramping
☐ Vomiting ☐ Laxative use ☐ Stomach cramps
☐ Acid Regurgitation ☐ Hard stools ☐ IBS
☐ Gas ☐ Hemorrhoids ☐ Itchy anus
☐ Hiccup ☐ Black stools ☐ Burning anus
☐ Bloating after meals ☐ Blood in stools ☐ Rectal pain
☐ Bad breath ☐ Mucus in stools ☐ Ulcerative colitis
☐ Gurgling sounds ☐ Undigested food in stools ☐ Gastritis
☐ Diarrhea ☐ Loose stools ☐ Enteritis

# of bowel movements per day: _____

Please check boxes that are relevant to you pertaining the head, eyes, ears, nose and throat:

☐ Glasses ☐ TMJ ☐ Sinus problems
☐ Eye strain ☐ Grinding Teeth ☐ Clear throat often
☐ Red eyes ☐ Soft teeth ☐ Recurrent sore throat
☐ Itchy eyes ☐ Gum disease ☐ Swollen glands
☐ Spots in eyes ☐ Sore gums ☐ Lumps in throat
☐ “Floaters” in vision ☐ Bleeding gums ☐ Enlarged thyroid
☐ Poor vision ☐ Multiple cavities ☐ Nose bleeds
☐ Blurred vision ☐ Dry mouth ☐ Ringing in ears
☐ Night blindness ☐ Sores on tongue ☐ Poor hearing
☐ Glaucoma ☐ Sores on lips ☐ Earaches
☐ Cataracts ☐ Excessive saliva

☐ Headaches ☐ Migraines ☐ Concussions

Please check boxes that are relevant to your respiratory conditions:

- ☐ Feeling short of breath
- ☐ Chest oppression
- ☐ Tightness in chest
- ☐ Chronic cough
- ☐ Difficulty breathing lying down
- ☐ Asthma/wheezing
- ☐ Dry cough
- ☐ Productive cough with:
  - ☐ A lot of sputum
  - ☐ Very little sputum
  - ☐ Clear sputum
  - ☐ Sticky sputum
  - ☐ Green sputum
  - ☐ Blood in sputum

Please check boxes that are relevant to you pertaining your sleep patterns:

- ☐ Insomnia
- ☐ Troubles falling asleep
- ☐ Problems staying asleep
- ☐ Wake up tired
- ☐ Dream disturbed sleep
- ☐ Nightmares
- ☐ Waking up in the night: time(s) that you wake at: _____

Please check boxes that are relevant to the condition(s) of your skin and hair:

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Shingles
- ☐ Dry skin
- ☐ Itchy skin
- ☐ Acne
- ☐ Oily skin
- ☐ Fungal infections
- ☐ Dandruff
- ☐ Premature grey hair
- ☐ Alopecia/hair loss
- ☐ Brittle hair

Please check boxes that are relevant to your genito-urinary conditions:

- ☐ Painful urination
- ☐ Burning urination
- ☐ Frequent urination
- ☐ Copious urination
- ☐ Scanty urination
- ☐ Dark yellow urine
- ☐ Light yellow urine
- ☐ Clear urine
- ☐ Cloudy urination
- ☐ Retention of urine
- ☐ Frequent bladder infections
- ☐ Frequent kidney infections
- ☐ Urinary incontinence
- ☐ Urination at night

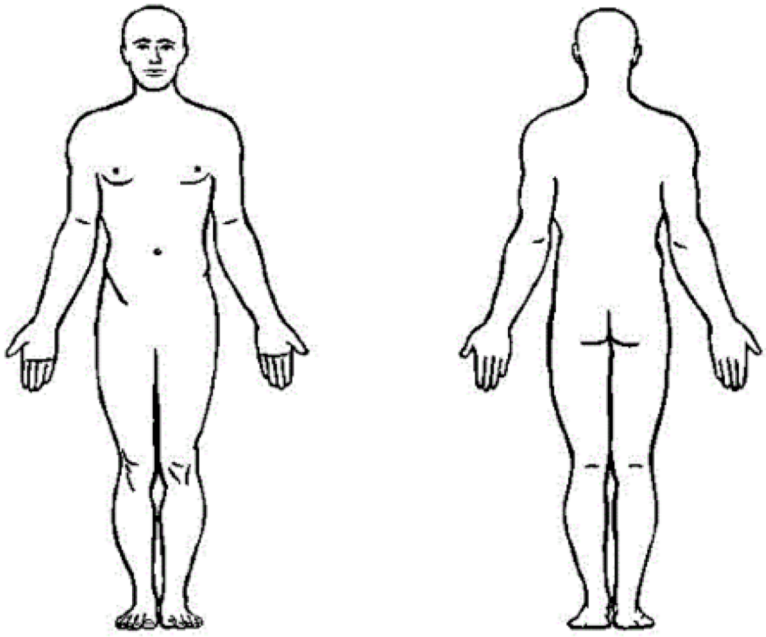
Please check boxes that are relevant to your neuro-psychological conditions:

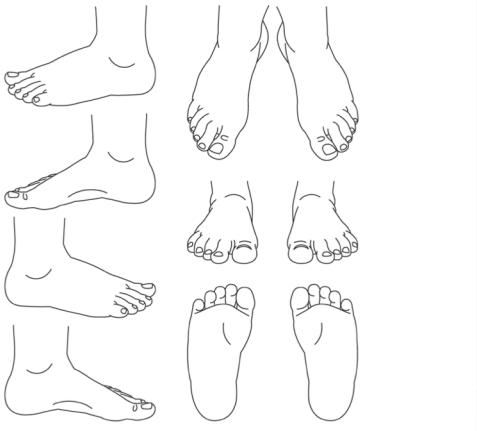
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Easily stressed
- ☐ Abuse survivor
- ☐ ADHD
- ☐ Parkinson's
- ☐ Trigeminal Neuralgia
- ☐ Bell's palsy
- ☐ Fainting

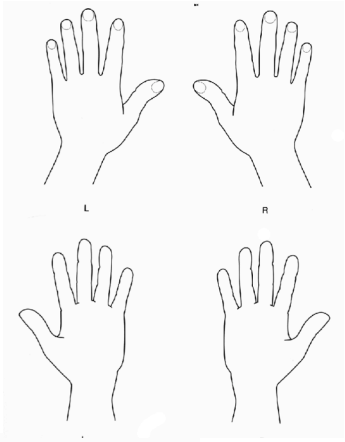
Please check boxes that are relevant to your musculoskeletal conditions:

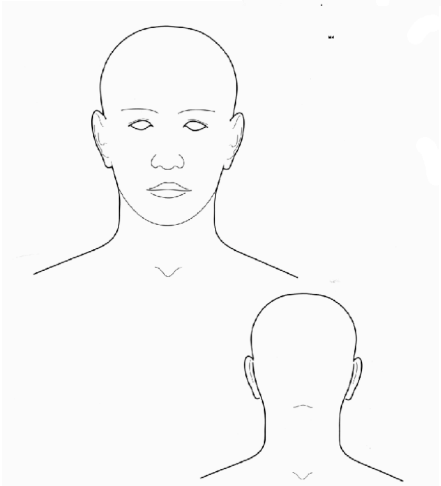
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Elbow pain
- ☐ Hand pain
- ☐ Finger pain
- ☐ Chest pain
- ☐ Rib pain
- ☐ Abdominal pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Lower back pain
- ☐ Leg pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Toe pain

Please indicate areas of pain or symptoms:









CONSENT FOR TREATMENT

I, _____, hereby request and CONSENT to treatment utilizing any combination of the following: acupuncture, cupping, guasha, moxabustion, herbal prescriptions, Chinese physical therapy (tuina), physical therapy, exercise therapy, joint mobilizations, and massage therapy to be performed by practitioners at Fort Saskatchewan Acupuncture Ltd.

I understand with acupuncture treatment that there are some very slight risks to treatment, including but not limited to: bruising, minor bleeding, pain and discomfort. I understand that sterile, single use needles are used in all treatments.

I authorize sharing of relevant health information between Fort Saskatchewan Acupuncture practitioners for the purpose of treatment coordination.

I have had the opportunity to discuss with office/clinic personnel the nature and purpose of therapies mentioned above. I understand that results are not guaranteed.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned modalities of treatment. I intend this consent form to cover the entire course of treatment for any and all conditions treated at Fort Saskatchewan Acupuncture.

_____ (Patient/Guardian Signature)

Signed this _____ day of _____, 20_____

Fort Saskatchewan Acupuncture

#301, 10101 86 Ave
Fort Saskatchewan, AB, T8L 0T6
(587) 285-8012
www.fortsaskacupuncture.com

PAYMENT AND APPOINTMENT POLICIES

Patients are responsible for all payments for treatments and supplements. For your convenience, direct billing for insurance coverage is provided. However, the patient is responsible for payment of all outstanding dues not covered by the insurance provider.

For your convenience, appointments may be booked online or by telephone. Cancellations of at least 24 hours prior to appointment time may also be done via our online booking system or by telephone. However, appointment cancellations without 24-hour notice will be charged a $45 cancellation fee.

I, _____, understand and agree to the payment and appointment policies of Fort Saskatchewan Acupuncture Ltd.

_____ (Patient/Guardian Signature)

Signed this _____ day of _____, 20_____

Fort Saskatchewan Acupuncture

#301, 10101 86 Ave
Fort Saskatchewan, AB, T8L 0T6
(587) 285-8012
www.fortsaskacupuncture.com