Name: _____ Date: _____
E-mail: _____

Under Canada's new Anti-Spam Legislation, we are required to ask you for your consent to contact you via e-mail.

Do you consent to Email Appointment Reminders? □ YES □ NO

Do you consent to information regarding your health being emailed? □ YES □ NO

_____
Please sign name here

DTCM, R.Acu

PATIENT INTAKE FORM

Name: _____ Date: _____

Address _____

City _____ Province _____Postal Code _____

Home Tel. _____ Bus/Cell Tel. _____

E-Mail _____

Date or Birth (D/M/Y) _____ Age _____

Emergency Contact _____ Tel. # _____

Do you have extended Health Benefits _____ Do they cover Acupuncture _____

Who referred you to our office _____

Reason for consulting our office:

_____

_____

Expectations: _____

Prior Acupuncture Care:

Name of practitioner: _____ Telephone: _____

Physiotherapist or Acupuncturist: _____ If so when: _____

Results Achieved: Excellent_____ Good_____ Fair_____ Poor_____

Medical Doctor:

Name: _____ Telephone: _____

Address: _____

Date of last appointment: _____ Date of last physical: _____

Medical Specialist:

Name: _____Telephone: _____

Specialty: _____ Date of last appointment: _____

Dentist:

Name: _____ Telephone: _____

Location: _____ Date of last appointment: _____

List of past dental procedures: _____

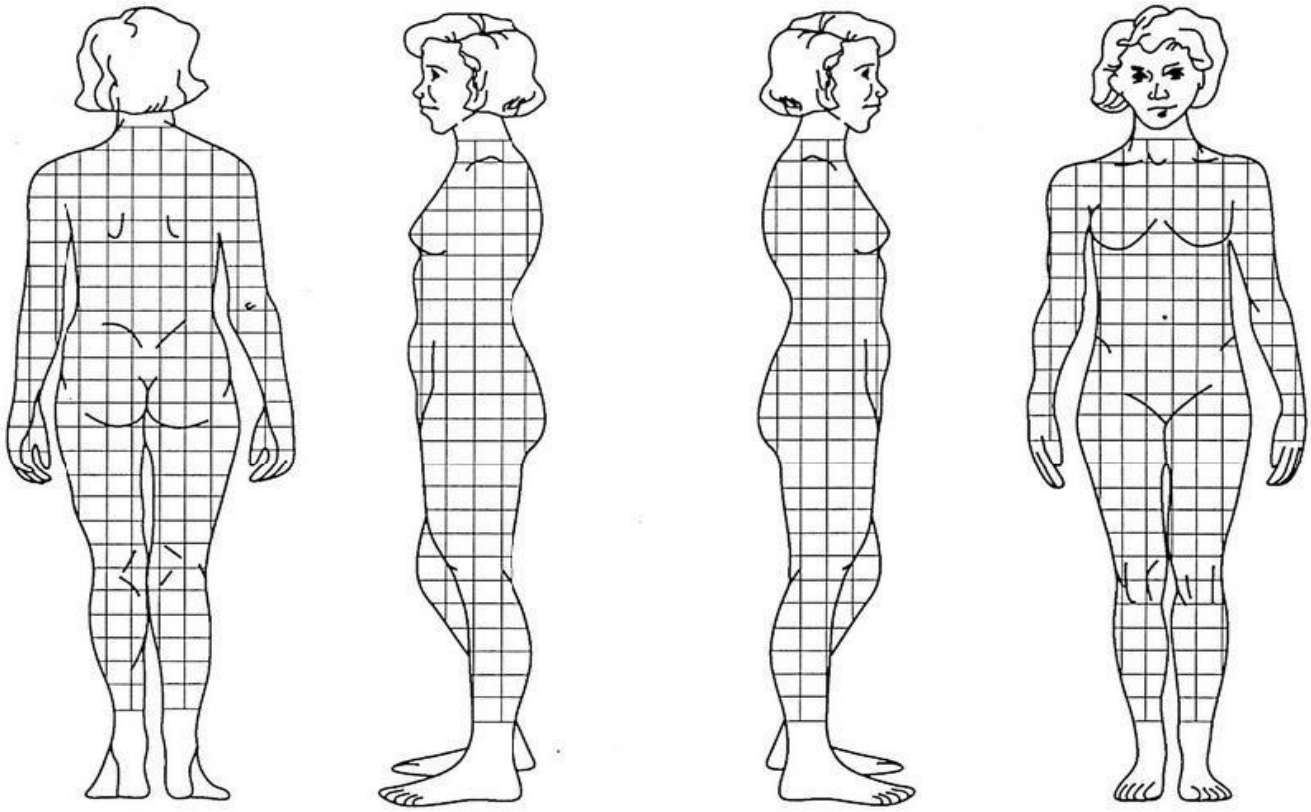
_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull **S** = Stabbing/Sharp

B = Burning **T** = Tingling (pins & Needles)

N = Numb **C** = Cramping



Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social, and spiritual condition over the past one month. Use an X on the line to mark the point that summarizes your overall sense of well-being for the past month.

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

Worst you have ever been Best you have ever been

Please list current medications and the condition(s) they are treating:

_____

_____

_____

BODY SYSTEM REVIEW Headache:

Location: _____ How often: _____ Type of Pain: _____

Dizziness: _____ Numbness/Tingling: _____

Eyes: Red: _____ Itchy: _____ Watery: _____ Blurry___:_____ Floaters:_____

Night Vision:_____ Glasses:_____

Ears: Ringing: _____ Pitch:_____ Other:_____

Gums: Bleeding: _____ Other: _____

Teeth: _____

Throat: Swollen glands/Sore throat: _____

Shortness of Breath: _____

Notes:_____

_____

BODY TEMPERATURE & PERSPIRATION

General Body Temp: Hot: _____Cold:_____ Where:_____

Chills: _____ Sense of Heat: _____

Hot Flashes: _____Night sweats: _____ Spontaneous:_____

Notes:_____

_____

DIET & THIRST

What do you eat:_____

What do you NOT eat:_____

How does food affect you: Tired_____ Bloating_____ Gas_____ Burping_____ Pain_____

Other_____

How is your appetite: _____ Cravings: _____

Eat 3 meals/day: Yes____ No_____ Skip meals _____ Taste in Mouth: _____

Daily Liquid Consumption: _____ Cold or hot liquids: _____ Add Ice? Yes___ No____

Caffeine: _____ Tobacco: _____ Alcohol: _____

Notes:_____

_____

ELIMINATION

Urination: Output per day: _____ Color: _____ Blood: _____ Cloudy: _____

Urgent: _____ Burning:_____ Retention: _____ Scanty: _____Dribbling: _____

Night time: _____ Times/Night: _____

Notes:_____

_____

Stools: Frequency: _____ Hard: _____ Loose: _____Formed: _____

Complete: Y___ N____ Constipation: _____ Diarrhea: _____ Alternating: _____

Difficulty: _____ Undigested Food: _____ Blood: _____ Mucus:_____

Notes:_____

_____

SLEEP

Hours/night: _____ Time to bed: _____ Time to wake: _____

Rested when wake up: _____ Trouble falling asleep: _____

Waking in the night: _____Trouble going back to sleep: _____

Dreams: _____

Worries/Thoughts: _____ Palpitations:_____

Notes:_____

EMOTIONS

At this time: _____

Mood swings _____Anxiety _____ Depression _____ Irritability _____

History of abuse _____ Attempted suicide _____Stress Level: _____

Notes:_____

_____

FEMALE

Pregnant?: Yes____ No_____ Length of Cycle: _____ # Days Bleeding:_____

Pain:_____ When: _____ Clots:_____ Flow:_____

Color_____:_____ PMS:_____

Irritable:_____ Mood Swings:_____ Breasts Tender:_____

Cravings:_____ Fatigue:_____

Birth Control: _____ Pregnancies_____ Births:_____ Miscarriages:_____

Menarche Age: _____ Vaginal Discharge:_____ Yeast Infections:_____

Menopause: Age at Onset: _____ Hot Flashes:_____ Night Sweats: _____

Notes:_____

_____

MALE

Prostate:_____ Sexual function_____

Dysfunction:_____

Notes:_____

_____

Any other information you feel may be helpful concerning your diagnosis and treatment:

_____

_____

_____

_____

_____

_____

_____

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_____

Chinese Medicine & Acupuncture Clinic

Disclosure Statement & Informed Consent

Insurance: We direct bill Blue Cross insurance only. We will provide you with a receipt for any other insurance company upon request.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

I understand that Acupuncture treatment provided to me by the Doctor of Traditional Chinese Medicine and/or Registered Acupuncturist (DTCM/R.Ac) is without a Chiropractic Exam/Assessment & is separate and distinct from the practice of Chiropractic provided by Dr. Caitlin Zietz and Dr. Chris Yavis at Complete Health. I hereby waive all liability toward the above mentioned doctors should any injury or malpractice occur from any treatment by DTCM/R.Ac.

Signature: _____ Date: _____

Signature of patient (or legal guardian)

Signature of Practitioner: _____ Date: _____

Cancellation Policy

We require **24 hours notice** for cancellation of Chiropractic, Acupuncture, Naturopath and Massage appointments otherwise the full cost of the treatment will be charged to you.
We understand some circumstances are beyond your control, so please discuss with us when cancelling.
No shows will be charged the full treatment amount.

_____

Patient Signature