SPRUCE GROVE
Acupuncture
& Traditional Chinese Medicine

NEW PATIENT INTAKE FORM

Holistic Nutrition Consultation

Today's Date: MM / DD / YY

PERSONAL INFORMATION	
Name:	**Birthdate:** MM / DD / YYYY
Address:	**Marital Status:**
City:	**Email Address:**
Province:	**Do you wish to receive appointment confirmations and reminders by email?** ☐ Yes ☐ No
Postal Code:	
Home Phone:	**Cell Phone:**
Work Phone:	**Occupation:**
Emergency contact name & phone number:	**Were you referred to our clinic?** ☐ Yes ☐ No If yes, by whom?
INSURANCE INFORMATION	
Insurance Company:	**Plan Member's Name:**
Policy/Group Number:	**ID Number:**
HEALTH INFORMATION	
Age: **Height:** **Weight:**	**Gender:** ☐ M ☐ F ☐ Non-binary
What motivated you to book a Nutrition Consultation?	
What are the top health concerns/complaints you would like to address with diet and lifestyle changes?	
What do you feel might hold you back from making these changes?	
Family physician's name & phone number:	**Are you under the care of a physician now?** ☐ Yes ☐ No If yes, what for?

HEALTH INFORMATION continued		
Stress and Energy Levels	**From 1-10, what is your stress level like on a typical day?** 1 = "I can manage fine" 10 = "The stress is unbearable"	**From 1-10, what is your energy level like on a typical day?** 1 = "It's an accomplishment to get out of bed" 10 = "I always have energy to get through my day"
Morning:		
Afternoon:		
Evening:		

How does your stress manifest itself?

What are your coping mechanisms/habits to manage stress, and do they help?

What do you do for exercise?

How many hours (on average) do you sleep per night?	**What time do you go to sleep?**	**What time do you wake up?**

Do you sleep well?	☐ Yes ☐ No ☐ Sometimes	**Do you enjoy your work?**	☐ Yes ☐ No ☐ Sometimes

Do you wish to change your weight?	☐ Gain weight How much? _____	☐ Lose weight How much? _____	☐ Neither

What is the main motivation for this weight change?

MEDICAL HISTORY

Your Medical History

Do you have any allergies? ☐ Yes ☐ No
If yes, to what?

Do you take any medications? ☐ Yes ☐ No
If yes, please list types, dosage and reason for taking.

MEDICAL HISTORY continued

Your Medical History continued

Do you take any vitamins/supplements? ☐ Yes ☐ No
If yes, please list types, dosage and reason for taking.

Have you had surgery to remove: ☐ Gallbladder ☐ Tonsils ☐ Appendix

How often do you have a bowel movement?

Do you experience any of the following?

- ☐ Straining
- ☐ Loose stools
- ☐ Undigested food in stools
- ☐ Cramps
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Yellow stool
- ☐ Consistent brown colour

Gynecological

Are you currently using hormonal birth control? ☐ Yes ☐ No
If yes, what kind and for how long?

Do you have any PMS symptoms? ☐ Yes ☐ No
If yes, what do you experience?

How long is your cycle?

Are you pregnant or trying to conceive? ☐ Pregnant ☐ Trying to conceive ☐ Neither

Do you have any menopause symptoms? ☐ Yes ☐ No
If yes, what do you experience?

Have you ever had a bone density test? ☐ Yes ☐ No

Genitourinary

Have you ever experienced any prostate problems? ☐ Yes ☐ No
If yes, what do you experience?

Family Medical History (please check all that apply to your family and/or yourself)

- ☐ Allergies (please list) _____ _____ _____ _____
- ☐ Alcoholism/Addiction
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Diabetes (type: _____)
- ☐ Cancer (type: _____)
- ☐ Gall Bladder Issues
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Intestinal Disease
- ☐ Kidney Dysfunction
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Skin Conditions
- ☐ Ulcers
- ☐ Other: _____ _____ _____

FOOD INTAKE AND SYMPTOMS

What are your favourite foods? How often do you eat them?

What foods do you crave? How often do you eat them?

FOOD INTAKE AND SYMPTOMS continued					
Blood Sugar **Please indicate the frequency: 1 = once a month; 2 = once a week; 3 = more often than once a week**					
Crave sweets during the day		Irritable if meals are missed		Family history of diabetes	
Eating relieves fatigue		Frequent 'midnight snacks'		Fainting spells	
Tired after meals		Prone to infections and colds		Forgetful, poor memory	
Hungry a few hours after eating		Agitated, easily upset, nervous		Feeling shaky sometimes	
Feel better or calmer after eating		Must have sweets after meals		**Total for this section:**	
Most likely a problem: >30		**May be a problem: 14-30**		**May not be an issue: <14**	
Adrenal Insufficiency **Please indicate the frequency: 1 = once a month; 2 = once a week; 3 = more often than once a week**					
Cannot stay asleep		Headache with exertion or stress		Eyes sensitive to bright or direct light	
Slower moving in the morning		Crave salt		Stress or emotional upset cause exhaustion	
Dizziness when standing up quickly		Afternoon fatigue		Unable to tolerate too much exercise	
Weak nails		Afternoon headaches		Catch colds or get sick easily	
				Total for this section:	
Most likely a problem: >23		**May be a problem: 11-23**		**May not be an issue: <11**	
Adrenal Hyperfunction **Please indicate the frequency: 1 = once a month; 2 = once a week; 3 = more often than once a week**					
Cannot fall asleep		Wake up tired after 6 or more hours of sleep		Under a high amount of stress	
Sweat easily		Excessive perspiration with little or no activity		Weight gain when under stress	
				Total for this section:	
Most likely a problem: >10		**May be a problem: 5-9**		**May not be an issue: <4**	

DIET				
3-Day Sample Menu **Please provide examples of what you eat and drink on three (3) typical days.**				
	Approx. time of day	**Day 1**	**Day 2**	**Day 3**
Snack/drink				
Breakfast				
Snack/drink				
Lunch				
Snack/drink				
Supper				
Snack/drink				

Informed Consent for Holistic Nutrition Consultation

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Print Name: _____ Signature: _____

Date: _____

Cancellation Policy

If you need to reschedule your appointment please be sure to call our clinic 24 hours before your scheduled appointment time so that this time can be made available to another patient. If you do not reschedule 24 hours in advance or if you miss your scheduled appointment you will be charged the full fee. Thank you for your consideration and understanding.

Signature: _____

Date: _____