SPRUCE GROVE
Acupuncture
& Traditional Chinese Medicine

NEW PATIENT INTAKE FORM

Today's Date: MM / DD / YY

PERSONAL INFORMATION	
Name:	**Birthdate:** MM / DD / YYYY
Address:	**Marital Status:**
City:	**Email Address:**
Province:	**Do we have permission to email you regarding products and services, and general health information?** ☐ 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?
Have you had Acupuncture before? ☐ Yes ☐ No If yes, how was your experience?	**Have you had Chinese herbal medicine before?** ☐ Yes ☐ No

INSURANCE INFORMATION	
Insurance Company:	**Plan Member's Name:**
Policy/Group Number:	**ID Number:**

HEALTH INFORMATION			
Age:	**Height:**	**Weight:**	**Gender:** ☐ M ☐ F ☐ Non-binary
Reason for visit today:			
How long have you had this condition?		**Does it bother your:**	☐ Sleep ☐ Work ☐ Other: _____
What was the initial cause?		**What seems to make it better?**	
What seems to make it worse?		**Other concurrent therapies:**	
Family physician's name & phone number:		**Are you under the care of a physician now?** ☐ Yes ☐ No If yes, what for?	

MEDICAL HISTORY

Family Medical History (please check all that apply)

☐ Allergies (please list) _____ _____	☐ Arteriosclerosis ☐ Asthma ☐ Alcoholism/Addiction	☐ Cancer (type: _____) ☐ Depression	☐ Diabetes (type: _____) ☐ Heart Disease ☐ High Blood Pressure	☐ Seizures ☐ Stroke ☐ Other: _____

Your Medical History

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

Do you sleep well? ☐ Yes ☐ No
Average hours of sleep per night:

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

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

List any past surgeries:

List any significant trauma & when it occurred:

Please check any of the following conditions you currently have, have had in the past, or if you feel any of the following are a significant part of your medical history.

☐ AIDS/HIV	☐ Birth Trauma (your own)	☐ Gout	☐ Rheumatic Fever	☐ Polio
☐ Alcoholism/Addiction	☐ Cancer	☐ Heart Disease/Attack	☐ Scarlet Fever	☐ Tuberculosis
☐ Allergies	☐ Chicken Pox	☐ Hepatitis (Type: _____)	☐ Mental Illness	☐ Typhoid Fever
☐ Anemia	☐ Diabetes (Type: _____)	☐ Herpes (Type: _____)	☐ Multiple Sclerosis	☐ Ulcers
☐ Appendicitis	☐ Drug Reaction	☐ High Blood Pressure	☐ Mumps	☐ STI
☐ Arteriosclerosis	☐ Emphysema	☐ Hyperthyroid	☐ Pacemaker	☐ Whooping Cough
☐ Arthritis	☐ Epilepsy	☐ Hypothyroid	☐ Parasites	☐ Seizures
☐ Asthma	☐ Gall Stones	☐ Kidney Stones	☐ Pleurisy	☐ Stroke
☐ Blood Transfusion	☐ Goiter	☐ Measles	☐ Pneumonia	☐ Other: _____

Lifestyle

What are your hobbies?

Do you exercise regularly? ☐ Yes ☐ No
If yes, type and frequency.

Do you use any of the following daily?
☐ Tobacco
☐ Alcohol
☐ Marijuana
☐ Drugs

Do you experience any of the following?
☐ Stress
☐ Occupational Hazards

Diet

Is your appetite: ☐ Low ☐ High

Is your protein intake: ☐ Low ☐ High

Glasses of Water per

Do you consume any of the following daily?
☐ Coffee/Tea
☐ Pop/Juice
☐ Artificial Sweeteners
☐ Sugar
☐ Added Salt
☐ Gluten
☐ Dairy Products

Average Daily Menu (please complete if you have digestive concerns to discuss with your practitioner)

Morning:	Snack:	Noon:	Snack:	Evening:	Snack:

MEDICAL HISTORY continued

General Symptoms (check all that apply)

- ☐ Poor Appetite
- ☐ Heavy Appetite
- ☐ Strongly Like Cold Drinks
- ☐ Strongly Like Hot Drinks
- ☐ Recent Weight Loss/Gain
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Dream-disturbed Sleep
- ☐ Fatigue
- ☐ Lack of Strength
- ☐ Bodily Heaviness
- ☐ Cold Hands or Feet
- ☐ Poor Circulation
- ☐ Shortness of Breath
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Muscle Cramps
- ☐ Vertigo or Dizziness
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Taste (describe)

_____

_____

_____

Head, Eyes, Ears, Nose & Throat (check all that apply)

- ☐ Glasses/Contact Lenses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Spots in Eyes
- ☐ Poor Vision
- ☐ Double Vision
- ☐ Night Blindness
- ☐ Myopia/Presbyopia
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth Problems
- ☐ Grinding Teeth/Bruxism
- ☐ TMJ
- ☐ Facial Pain
- ☐ Gum Problems
- ☐ Sores on Lips or Tongue
- ☐ Dry Mouth/Throat
- ☐ Excessive Saliva
- ☐ Difficulty Swallowing
- ☐ Sinus Problems
- ☐ Excessive Phlegm
  Color: _____
- ☐ Swollen Glands
- ☐ Lump in Throat
- ☐ Enlarged Thyroid
- ☐ Nosebleeds
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Recurrent Sore Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Concussion
- ☐ Other head or neck problems:

_____

_____

_____

Respiratory (check all that apply)

- ☐ Difficulty Breathing when Lying Down
- ☐ Shortness of Breath
- ☐ Asthma/Wheezing
- ☐ Difficult Inhalation
- ☐ Difficult Exhalation
- ☐ Cough
  - ☐ Wet
  - ☐ Dry
  - ☐ Thick
  - ☐ Thin
- ☐ Color of Phlegm: _____
- ☐ Coughing Blood
- ☐ Tight Chest
- ☐ Pneumonia

Cardiovascular (check all that apply)

- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Tachycardia
- ☐ Heart Palpitations
- ☐ Phlebitis
- ☐ Irregular Heartbeat

Gastrointestinal (check all that apply)

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ Gas/Belching
- ☐ Hiccup
- ☐ Bloating
- ☐ Bad Breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black/Dark Stools
- ☐ Blood in Stools
- ☐ Mucous in Stools
- ☐ Hemorrhoids
- ☐ Itchy Anus
- ☐ Intestinal Pain/Cramping
- ☐ Burning Anus
- ☐ Rectal Pain
- ☐ Anal Fissures
- ☐ Laxative Use

  What kind? _____

  How often? _____
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Ulcers
- ☐ Odorous Stools

Bowel Movements:

Frequency _____

Color _____

Texture _____

Musculoskeletal (check all that apply)

- ☐ Neck/Shoulder Pain
- ☐ Muscle Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Joint Pain
- ☐ Rib Pain
- ☐ Limited Range of Motion
- ☐ Limited Use
- ☐ Muscle Cramps
- ☐ Other: _____

Skin and Hair (check all that apply)

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in Skin/Hair Texture
- ☐ Fungal Infection
- ☐ Other:

_____

_____

Neuropsychological (check all that apply)

- ☐ Seizures
- ☐ Numbness
- ☐ Tic/Tremor
- ☐ Poor Memory/Confusion
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily Stressed
- ☐ Abuse Survivor
- ☐ Considered/Attempted Suicide
- ☐ Seeking Therapy
- ☐ Other:

_____

_____

Genitourinary (check all that apply)

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgent Urination
- ☐ Blood in Urine
- ☐ Unable to Hold Urine
- ☐ Incomplete Urination
- ☐ Waking to Urinate
- ☐ STI
- ☐ Bedwetting
- ☐ Increased Libido
- ☐ Decreased Libido
- ☐ Kidney Stones
- ☐ Nocturnal Emission
- ☐ Erectile Dysfunction
- ☐ Premature Ejaculation

MEDICAL HISTORY continued

Gynecological

Date last period began: **Is your cycle regular?** ☐ Yes ☐ No

Age menses began: **Length of cycle (day 1 to day 1):** **Duration of flow:**

Date of last Pap test: **Age at menopause:**

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

Number of Pregnancies: _____
Number of Live Births: _____
Number of Premature Births: _____

Please check any of the following conditions/concerns you have:

- ☐ PMS
- ☐ Clotting
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Vaginal Odor
- ☐ Vaginal Discharge
  Color: _____
- ☐ Vaginal Sores/Pain
- ☐ Breast Lumps
- ☐ Other: _____

Pain

Use the diagram and pain key to the right to indicate area(s) and type(s) of pain. Use the chart below to describe pain intensity and limitations.

Pain intensity levels
☐ No pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping
☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Can't sleep

Work – Can do:
☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

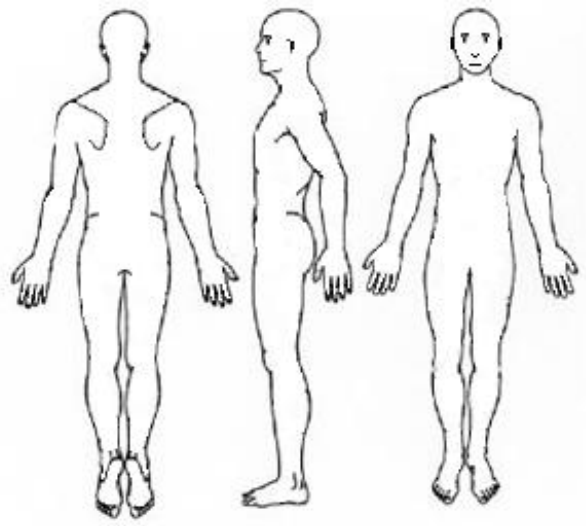
Frequency of pain
☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel
☐ No problem ☐ Some pain on trips ☐ Severe pain

Recreation – Can do:
☐ All activities ☐ Some activities ☐ No activities

Walking
☐ No problem ☐ Pain after short walk ☐ Cannot walk

Sitting
☐ No problem ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Tingling	Burning	Stabbing
^^^^	= = = =	0 0 0 0	X X X X	/ / / /

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Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintain overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive.
- Minor bleeding or bruising can occur from acupuncture.
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
- Fainting can occur in certain patients, particularly at the first treatment.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping.
- The herbs and nutritional supplements from plant and mineral sources that have been recommended are traditionally considered to be safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations
- If you have a pacemaker or any other electrical implants
- If you are pregnant
- If you have a bleeding disorder
- If you are taking anti-coagulants (blood thinners) or any other medication
- If you have damaged heart valves or have any other particular risk of infection

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgement during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Print full name: _____ Signature: _____

Date: _____

Print name of representative if represented by another: _____

Signature of representative: _____

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: _____