SPRUCE GROVE
Acupuncture
& Traditional Chinese Medicine

NEW PATIENT INTAKE FORM

Manual Osteopathic Therapy

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?
Have you had Manual Osteopathic Therapy before?	☐ Yes ☐ No If yes, how was your experience?
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
- ☐ Alcoholism/Addiction
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Birth Trauma (your own)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes (Type: _____)
- ☐ Drug Reaction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Stones
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease/Attack
- ☐ Hepatitis (Type: _____)
- ☐ Herpes (Type: _____)
- ☐ High Blood Pressure
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Kidney Stones
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Parasites
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ STI
- ☐ Whooping Cough
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

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

MEDICAL HISTORY continued

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

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: _____

MEDICAL HISTORY continued

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:

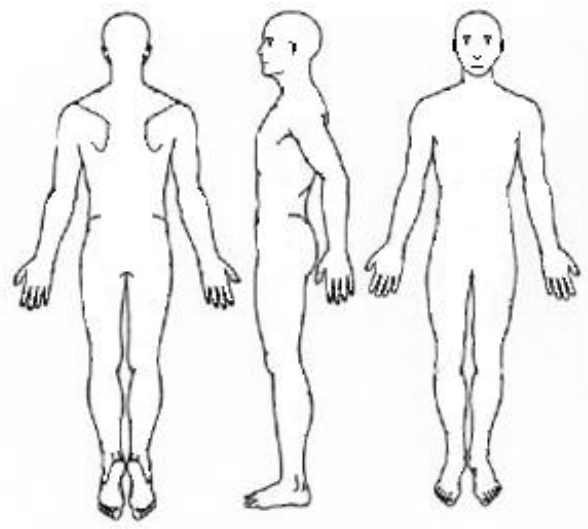
☐ All activities ☐ Some activities ☐ No activities

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	/ / / /

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: _____

INFORMED CONSENT TO MANUAL OSTEOPATHIC TREATMENT

Manual Osteopathic Treatment is a non-invasive therapy for the treatment of conditions including neuromusculoskeletal and joint complaints. The proposed treatments may contain therapies such as gentle mobilization of the joints, muscles, connective tissue, fluids, viscera and nerve pathways.

Treatments include manual techniques where the practitioner places their hands on your body. This may involve contact whereby hands are placed on sensitive areas such as the chest wall, pelvic floor, and pubic bones. The removal of some items of clothing may be required if they are obstructive to certain techniques and manipulations. If you do not feel comfortable with any part of the procedure, please inform the practitioner. Techniques can be discontinued or modified as per consent.

I acknowledge and understand that the Manual Osteopathic Practitioner must be completely aware of my existing medical conditions. It is my responsibility to keep the practitioner updated on any medical concerns and the information provided is true and complete to the best of my knowledge. I also recognize that manual osteopathic treatment is not a substitute for medical treatments and/or medications. I understand that it is recommended that I work concurrently with any other primary medical professionals for any conditions I have.

It is your right and responsibility to inform the practitioner of your condition during the course of treatment. The practitioner reserves the right to discontinue services where it is apparent that your expectations and the type of therapies provided may not be compatible.

I understand that the results are not guaranteed. With this acknowledgement, I voluntarily give consent to Manual Osteopathic care and I am free to withdraw my consent at any time.

I hereby consent to the Manual Osteopathic Practitioner to provide treatment for the above noted purposes including assessments, examinations, and techniques which may be recommended.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Manual Osteopathic Practitioner may discuss my case with other healthcare providers and/or legal bodies if needed. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

By signing this form, I intend to this consent to cover the treatments discussed with me to deal with my physical, emotional, and mental conditions and for which I have sought treatment.

Print Name: _____ Signature: _____

Date: _____