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 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 Acupuncture before? ☐ Yes ☐ No If yes, how was your experience?	**Have you had Chinese herbal medicine before?** ☐ Yes ☐ No

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

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?	

☐ Update email preference

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 Day:**	
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

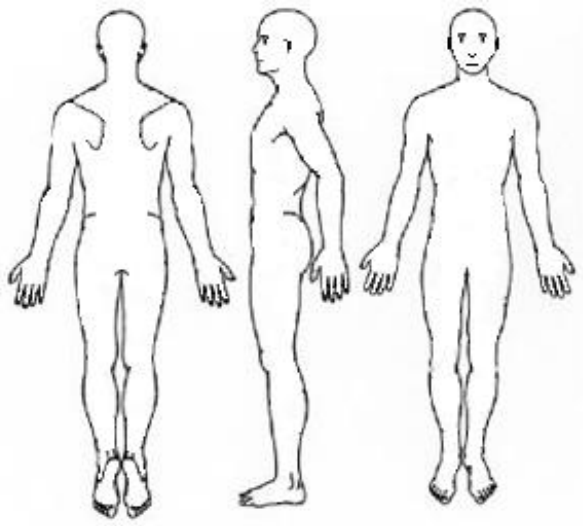
Frequency of pain
☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

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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Clinic Policies

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 with at least 24 hours' notice, or if you miss your scheduled appointment you will be charged the full fee. Thank you for your consideration and understanding.

Initials: _____

Direct Billing to Third Parties

We are pleased to offer direct-billing for acupuncture services to many extended health benefits providers, and to vehicle insurance providers in cases of Motor Vehicle Accidents under the Diagnostic & Treatment Protocols and/or Section B Accident Benefits. If you authorize Spruce Grove Acupuncture Inc. to bill your extended health benefits/vehicle insurance provider directly for services and/or assign benefits payable to our clinic, you understand that:

- Your benefits/insurance plan may not cover the entire cost of the service
- You are responsible for any amounts owing that are not paid by your benefits/insurance
- Payment for any amounts owing is due upon receipt
- Direct-billing is not available for herbal consultations, Chinese herbal medicine, or manual osteopathic therapy treatment

Initials: _____

_____ Date: _____

Patient name (please print)

_____

Signature of patient (or legal guardian)