

NEW PATIENT INTAKE FORM

Today's Date: _____

PERSONAL INFORMATION			
Name:		Birthdate:	
Address:		Marital Status:	
City:		Email Address:	
Province:		Do you wish to receive appointment confirmations and reminders by email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Postal Code:			
Home Phone:		Cell Phone:	
Work Phone:		Occupation:	
Emergency contact name & phone number:		Were you referred to our clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom?	
Have you had Acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how was your experience?		Have you had Chinese herbal medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
INSURANCE INFORMATION			
Insurance Company:			
Policy/Group Number:		Plan Holder's Name:	
ID Number:		Plan Holder's Birthdate:	
HEALTH INFORMATION			
Age:	Height:	Weight:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-binary
Reason for visit today:			
How long have you had this condition?		Does it bother your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what for?	

MEDICAL HISTORY

Family Medical History (please check all that apply)

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Allergies (please list)
_____ | <input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Cancer (type: _____)
<input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes (type: _____)
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures
<input type="checkbox"/> Stroke
<input type="checkbox"/> Other: _____ |
|---|---|--|---|---|

Your Medical History

Do you have any allergies? If yes, to what?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you sleep well? Average hours of sleep per night:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you take any medications?
If yes, please list types and dosage. Yes No

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

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.

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

Lifestyle

What are your hobbies?	Do you exercise regularly? If yes, type and frequency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you use any of the following daily?	<input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Drugs	Do you experience any of the following?	<input type="checkbox"/> Stress <input type="checkbox"/> Occupational Hazards
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Diet

Is your appetite: <input type="checkbox"/> Low <input type="checkbox"/> High	Is your protein intake: <input type="checkbox"/> Low <input type="checkbox"/> High	Glasses of Water per Day:
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Do you consume any of the following daily?	<input type="checkbox"/> Coffee/Tea <input type="checkbox"/> Pop/Juice	<input type="checkbox"/> Artificial Sweeteners <input type="checkbox"/> Sugar	<input type="checkbox"/> Added Salt <input type="checkbox"/> Gluten <input type="checkbox"/> Dairy Products
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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)

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

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

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

Respiratory (check all that apply)

- | | | | | |
|--|---|--------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Difficulty Breathing when
Lying Down | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Cough | <input type="checkbox"/> Color of Phlegm:
_____ | <input type="checkbox"/> Tight Chest |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Difficult Inhalation | <input type="checkbox"/> Wet | | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Difficult Exhalation | <input type="checkbox"/> Dry | | |
| | | <input type="checkbox"/> Thick | <input type="checkbox"/> Coughing Blood | |
| | | <input type="checkbox"/> Thin | | |

Cardiovascular (check all that apply)

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Irregular Heartbeat |

Gastrointestinal (check all that apply)

- | | | | | |
|---------------------------------------|--|---|---|-------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal Pain/Cramping | <input type="checkbox"/> Abdominal Pain | Bowel Movements: |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning Anus | <input type="checkbox"/> Indigestion | Frequency _____ |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Black/Dark Stools | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Ulcers | Color _____ |
| <input type="checkbox"/> Gas/Belching | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Anal Fissures | <input type="checkbox"/> Odorous Stools | Texture _____ |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Mucous in Stools | <input type="checkbox"/> Laxative Use | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Hemorrhoids | What kind? _____ | | |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Itchy Anus | How often? _____ | | |

Musculoskeletal (check all that apply)

- | | | | | |
|---|--|-------------------------------------|--|--|
| <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Limited Use | <input type="checkbox"/> Other: _____ |

Skin and Hair (check all that apply)

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in Skin/Hair
Texture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal Infection | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair Loss | | _____ |

Neuropsychological (check all that apply)

- | | | | | |
|-------------------------------------|--|--|--|---------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor Memory/Confusion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/Attempted
Suicide | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily Stressed | <input type="checkbox"/> Seeking Therapy | _____ |
| <input type="checkbox"/> Tic/Tremor | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse Survivor | | _____ |

Genitourinary (check all that apply)

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Waking to Urinate | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Nocturnal Emission |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> STI | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Incomplete Urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> 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:

- | | | | |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> PMS | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Vaginal Odor | <input type="checkbox"/> Vaginal Sores/Pain |
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Vaginal Discharge
Color: _____ | <input type="checkbox"/> Breast Lumps |
| | | | <input type="checkbox"/> 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:

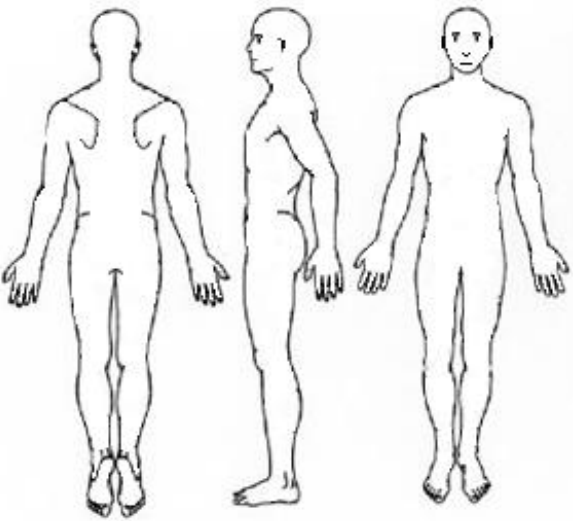
- All activities Some activities No activities

Walking

- No problem Pain after short walk Cannot walk

Sitting

- No problem Some pain while sitting Cannot sit



Pain Key

Ache ^^^	Numbness ====	Tingling 000	Burning XXXX	Stabbing ////
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INFORMED CONSENT TO TREATMENT

Practitioners at this clinic perform a variety of treatments, including acupuncture; other Traditional Chinese Medicine modalities including herbal medicine; Manual Osteopathic Therapy (MOT); and Craniosacral Therapy (CST). Not all modalities above may apply to my treatment today; however, I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncture is a complete system of medicine based on Traditional Chinese Medicine principles and modern scientific and physiologic systems. Treatments involve the insertion of fine, sterile, disposable needles into various points on the body with the aim to normalize physiologic function. Other techniques within the scope of practice of registered acupuncturists that may be used during my treatment include, but are not limited to: moxibustion, cupping, gua sha, laser acupuncture, and electro-acupuncture.

MOT 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 my body. This may involve contact whereby hands are placed on sensitive areas such as the chest wall, pelvic floor, and pubic bones.

CST is a gentle, hands-on method of evaluating and enhancing the functioning of a physiological body system called the craniosacral system, comprised of the membranes and cerebrospinal fluid that surround and protect the brain and spinal cord. Treatments include manual techniques where the practitioner places their hands on my body.

For many treatments received at this clinic, the removal of some items of clothing may be required if they are obstructive to certain techniques and manipulations. If I do not feel comfortable with any part of the treatment, I will inform the practitioner who can modify or discontinue techniques as per consent.

I understand that, as in all health care, in the practice of acupuncture, Traditional Chinese Medicine, MOT, and CST there may be slight risks to treatment including, but not limited to, muscle strains, ligament sprains, drowsiness or fainting, nausea, bleeding, bruising or tenderness, blistering, and exacerbation of the chief complaint or symptoms for 24-48 hours. More serious risks of acupuncture include infection and pneumothorax; however, I understand that the practitioner takes safety precautions to avoid these outcomes. I understand that the herbs and nutritional supplements from plant and mineral sources that the practitioner may recommend are traditionally considered to be safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

I acknowledge and understand that my practitioner must be completely aware of my existing medical and life conditions. It is particularly important that I let my practitioner know if I have a pacemaker or any other electrical implants; if I am pregnant; if I have a bleeding disorder; if I am taking blood thinners or any other medication; and if I have damaged heart valves or any other particular risk of infection. I agree to keep the practitioner updated on any medical conditions, and I understand there shall be no liability on the practitioner's part should I fail to do so. I agree that the information I have provided is true and complete to the best of my knowledge.

I do not expect the practitioner to be able to anticipate all risks and complications of treatment. I wish to rely on the practitioner to exercise their good judgement during the treatment which they feel at the time, based upon the facts then known, to be in my best interests. I understand that my comfort and consent are vital to my treatment, and I can ask questions and refuse or stop treatment at any time. I understand that treatments

provided at this clinic are not substitutes for a medical examination, medical treatment, or medication. I understand that it is recommended that I work concurrently with any other primary medical professionals for any conditions that I have. I understand that the practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the treatment given should be construed as such.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my practitioner may discuss my case with other healthcare providers and/or legal bodies if needed. I understand my practitioner may use a digital application to improve the efficiency and accuracy of medical documentation; any data collected in this manner is secure and encrypted.

I understand that results are not guaranteed. With this acknowledgement, I voluntarily give consent for treatment, and I am free to withdraw my consent at any time. I hereby consent to treatment as proposed to me.

Name (please print)

Date: _____

Signature of patient (or legal guardian)

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, craniosacral therapy, or manual osteopathic therapy treatment

Initials: _____