SPRUCE GROVE Acupuncture & Traditional Chinese Medicine

NEW PATIENT INTAKE FORM

Manual Osteopathic Therapy

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?** ☐ 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 (PLEASE NOTE: DIRECT-BILLING IS ONLY AVAILABLE WITH SOME INSURANCE COMPANIES)	
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
- ☐ 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:

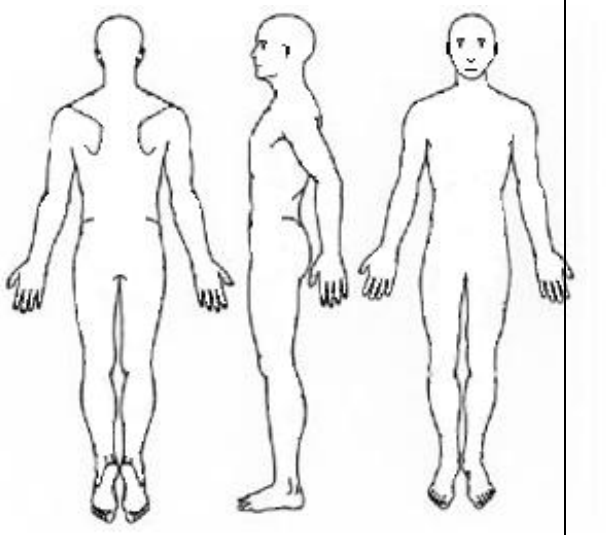
☐ All activities ☐ Some activities ☐ No activities

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	/ / / /

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)

_____ _____

Signature of patient (or legal guardian) Date

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: _____