Acupuncture New Patient Intake Form

Name:	DOB:	Age:
Address:	Weight:	Height:
City:	Occupation:	
Postal Code:	Emergency Contact Name & Number:	
Phone :		
Email:		
Would you like to receive our monthly email? Yes/No		
Do you have any allergies?		
Are you scent-sensitive?		
How did you find out about our clinic?		

What are your goals/expectations of your visit?	
Have you ever had acupuncture before? (circle one) Yes/No	Chinese herbal medicine? Yes/No

Conditions/Reasons for Visit (please rank by priority)	When did it start?	Frequency of conditions? (rare, occasional, regularly ebbs & flows, always there)	Is your condition worsening or stable?	Severity (circle one)
				mild/moderate/severe
				mild/moderate/severe
				mild/moderate/severe
				mild/moderate/severe

What is the ONE condition you'd like to concentrate on?		
Are your symptoms **better** or **worse** if you…..	Apply pressure?	Warmth?
	Cold?	Rest?
	Activity?	Other?
I would rate that this issue has on my current well-being as: Low 1 2 3 4 5 6 7 8 9 10 High		
Have you seen a medical doctor for this condition? Have you had any testing done?		
Dd you have a medical diagnosis and any recommendations for treatment?		
Have you had any other therapies in regards to this condition? (such as chiropractic, massage, physiotherapy, counseling, naturopath, etc)		

List type of therapy	How often did you go?	Did you find relief?	How long did it last?

Past Medical History: (please include date/year of diagnosis, surgery, injuries and results if available)

Family Medical History:	
Mother:	Father:

Lifestyle Habits(circle if applicable)			
Tobacco:	None	Cigars	Chewing tobacco
	Cigarettes	Duration of smoking	Frequency
Alcohol	None	Estimated drinks per week	
Other drugs	None	Type & Frequency	

Medical History (circle as applicable)

AIDS/HIV	Emphysema	MS	Ischemic stroke	Gastritis
Alcoholism	Epilepsy	Mumps	Hemorrhagic stroke	IBS
Appendicitis	Goiter	Pacemaker	Hyperthyroid	Anemia
Arteriosclerosis	Gout	Pleurisy	Hypothyroid	Anemia
Asthma	Heart disease	Pneumonia	Tuberculosis	Bronchitis
Birth trauma	Hepatitis	Polio	Typhoid fever	Osteo-arthritis
Cancer	Hypertension	Rheumatic fever	Ulcers	Enteritis
Chicken pox	Hypotension	Scarlet fever	Whooping cough	Rheumatoid Arthritis
Diabetes	Measles	Seizures	Colitis	

Medications/Supplements

Prescription and/or over the counter	Dose & Frequency	Reason	Duration of consumption	Cost per month

Diet, Lifestyle & Environment

Do you enjoy your work? Yes/No	Rate your overall level of stress Low 1 2 3 4 5 6 7 8 9 10 High			
Does your work involve lots of...	Standing	Sitting	Lifting	Walking
	Bending	Kneeling	Awkward positions	Computer work
	Mental stress	Shift Work	Concentration	
	Other:			
Describe your sleep patterns:				
What do you do to relax?				
How many servings of fruit do you usually consume in a day?				
How many servings of veggies do you usually consume in a day?				
How much water do you consume daily?				
How many caffeinated beverages do you consume a day? Include coffee/tea/pop				
Please circle anything relevant pertaining to your dietary conditions:				
	Poor appetite	Normal appetite	Excessive appetite	Crave sweets
	Crave salt	Bitter taste in mouth	Metallic taste in mouth	Sweet taste in mouth
	Sour taste in mouth	Other cravings?		
	No thirst	Very thirsty	Normal thirst	

Please check boxes that are relevant to you pertaining to your cardiovascular conditions:

High blood pressure	Lightheaded	Fast heartbeat	Orthostatic hypotension
Low blood pressure	Chest pain	Palpitations	Phlebitis
Fainting	Slow heartbeat	Irregular heartbeat	Heart Attack

Please check boxes that are relevant to you pertaining to your gastrointestinal conditions:

Nausea	Diarrhea	Undigested food in stools	Hemorrhoids
Vomiting	Constipation	IBS	Gastritis
Acid regurgitation	Laxative use	Stomach cramps	Enteritis
Gas	Black stools	Itchy anus	Hard stools
Hiccups	Blood in stools	Burning anus	Bloating after meals
Mucus in stools	Rectal pain	Bad breath	Intestinal cramping
Ulcerative colitis	Gurgling sounds	Loose stools	# of bowel movements/day:

Please check boxes that are relevant to you pertaining to your head, eyes, ears, nose, and throat:

Glasses	Blurred vision	TMJ	Excessive saliva	Nose bleeds
Eye strain	Night blindness	Gum disease	Sinus problems	Ringing in ears
Red eyes	Glaucoma	Sore gums	Clear throat often	Poor hearing
Itchy eyes	Cataracts	Bleeding gums	Recurrent sore throat	Earches
Sorts in eyes	Grinding teeth	Sores on lips	Swollen glands	Headaches
“Floaters” in vision	Soft teeth	Sores on tongue	Lumps in throat	Migraines
Poor vision	Multiple cavities	Dry mouth	Enlarged thyroid	Concussions

Please check boxes that are relevant to you pertaining to your respiratory condition:

Feeling short of breath	Tightness in chest	Chest oppression	Chronic cough
Difficulty breathing lying down	Asthma/wheezing	Dry cough	
Productive cough with:	A lot of sputum	Clear sputum	Sticky sputum
	Very little sputum	Green sputum	Blood in sputum

Mark on the diagram the area(s) where you feel **pain and/or discomfort** using the symbol which most closely describes what you feel. Please try to be as accurate as possible.

Tension/tightness	Pins and Needles	Burning	Aching	Stabbing	Coldness
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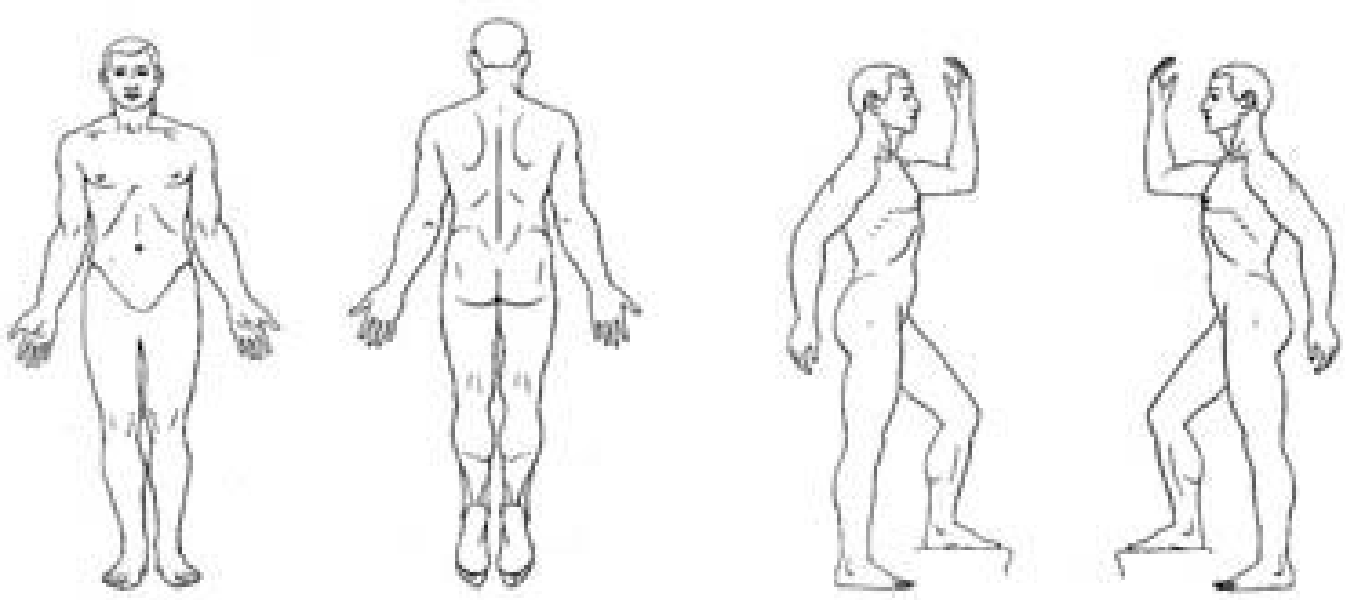

CONSENT FOR TREATMENT

I, _____, hereby request and CONSENT to treatment utilizing any combination of the following: acupuncture, herbal prescriptions, Chinese physical therapy (tui na), cupping, guasha, electro-acupuncture, food therapy, exercise therapy, and joint mobilizations to be performed by my acupuncturist at Stony Plain Acupuncture & Wellness. Therapies can also include massage, craniosacral treatment, and/or reiki by practitioners of Stony Plain Acupuncture & Wellness.

I understand with acupuncture treatment that there are some very slight risks to treatment, including but not limited to: bruising, minor bleeding, minor blisters, pain and discomfort. I understand that sterile, single use needles are used in all treatments.

I acknowledge that the practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I authorize sharing of relevant health information between _____ for the purpose of treatment coordination.

I have had the opportunity to discuss and ask any questions with office/clinic personnel the nature and purpose of therapies mentioned above.

I have read the above consent and by signing below I agree to the above-mentioned modalities of treatment. I intend this consent form to cover the entire course of treatment for any and all conditions treated at Stony Plain Acupuncture & Wellness.

_____ (Patient/Guardian Signature)

Signed this _____ day of _____, 20_____

Stony Plain Acupuncture & Wellness
4915A 44 Avenue
Stony Plain, AB
T7Z 1L5
780-963-4464

Cancellation Policy

We please request that you contact the clinic via telephone, at least 24 hrs prior to your appointment if you need to cancel or reschedule your appointment. This allows us the opportunity to be able to book in another patient who needs treatment and may be on the cancellation list.

If cancellation of appointment is within 24 hours of your appointment time, there will be a full charge for the appointment. No show policy is also 100% of the price of the treatment, which must be paid prior to any further appointment bookings. If there is a second no show, full price of the treatment will also be charged and full prepayment of services will be required upon booking your next appointment.

You should receive a reminder email 48 hours prior to your appointment. If you do not, please let us know and we can make sure your information is up to date in the system.

We do understand that some circumstances cannot be avoided, each situation is different and we would like to work with you, for the benefit of you and the practitioners to ensure that everyone's healing time is maximized.

Print Name: _____

_____ _____

Signature Date