Redefined Health

ACUPUNCTURE PATIENT INTAKE FORM

PATIENT INFORMATION

Name:_____Date:_____

Age:_____Weight:_____ Height:_____ Female :____ Male:____ Birth Date (dd/mm/yr):_____

Address:_____ Postal Code: _____

Home Ph:_____Cell Ph: _____ Work Ph:_____

Email:_____ Occupation:_____

How did you hear about the clinic?

_____

PRIMARY CONCERNS/COMPLAINTS:

1._____

2. _____

3._____

OPERATIONS AND HOSPITALIZATIONS

DATE	DIAGNOSIS	PROCEDURE

CURRENT MEDICATIONS/SUPPLEMENTS:

NAME	DOSE/FREQUENCY	REASON

PAIN:

Have you consulted a physician/dentist about the condition for which you are currently seeking treatment? Yes No

What caused the pain (brief summary)? _____

How long ago did the pain begin? _____

Was the onset sudden or gradual? _____

Does the pain interfere with your daily activities? _____

On a scale of 1 – 10 how would you rate your pain currently? (1 being lowest 10 being highest) _____

How would you describe the pain? (eg. shooting, stabbing, burning, throbbing, aching)

_____

Is the pain constant or does it come and go? _____

What activities make it worse? _____

What helps to alleviate the pain? _____

Please mark the location of your pain, following the legend on the next page.

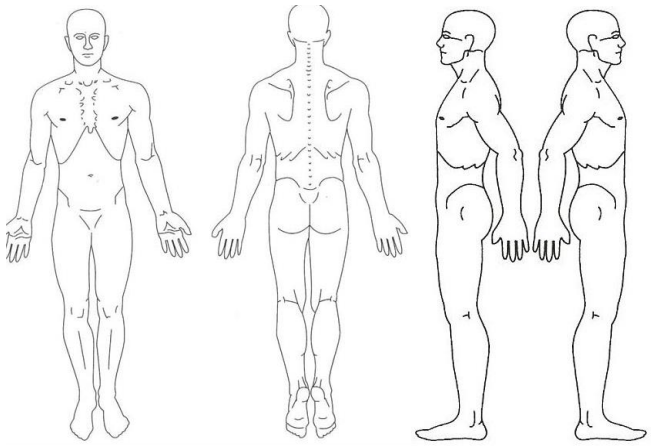
Key:

O=pain

X=tingling

N=numbness

→=radiates this direction



MEDICAL HISTORY

☐ AIDS/HIV	☐ bronchitis	☐ colitis	☐ ulcers
☐ arteriosclerosis	☐ pacemaker	☐ seizures	☐ hemorrhagic stroke
☐ gout	☐ hepatitis___	☐ emphysema	☐ IBS
☐ pleurisy	☐ rheumatoid arthritis	☐ MS	☐ diabetes type__
☐ fainting	☐ osteo-arthritis	☐ ischemic stroke	☐ goiter
☐ mononucleosis	☐ cancer	☐ gastritis	☐ hyperthyroid
☐ asthma	☐ hypertension	☐ epilepsy	☐ hypothyroid
☐ heart disease	☐ hypotension	☐ orthostatic hypotension	☐ anemia
☐ pneumonia			

LIFESTYLE:

Alcohol____(#)/week Tobacco____(#)/day Coffee/tea_____(#)/day Work stress: Yes/No

Exercise_____times/week and type:_____ Family stress: Yes/No

Hours of sleep/night:_____Number of bowel movements/day_____Glasses of water/day_____

Are you taking birth control or have you used birth control in the past? _____

TYPE:	FROM WHEN TO WHEN?	REASON DISCONTINUED

PMS SYMPTOMS:

	None	Before menstruation	During menstruation	At mid cycle
Emotional				
Breast tenderness				
Back pain				
Acne				
Headaches				
Bloating				
Cramps				

Emergency Contact Name: _____ Phone #: _____

CONSENT TO TREATMENT

I do hereby voluntarily consent to be treated with acupuncture, herbal therapy, cupping, electro-acupuncture and guasha administered at Redefined Health, 10118 124 Street NW, Edmonton, AB.

I understand that acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin, at certain point on or near the surface of the body. Acupuncture attempts to restore normal physiological body functions, modify or prevent pain perception.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and possibly temporary aggravation of symptoms.

I understand that acupuncture has been safely practiced for centuries. I also understand that no guarantees concerning its use and effects are given to me and that I am free to discontinue treatment at any time.

I have carefully read and understand all of the foregoing and I am fully aware of what I am signing.

Patient Name	Patient Signature	Date

Parent/Guardian Name	Parent/Guardian Signature	Date

Witness Name	Witness Signature	Date