Intake Form

Information

(Please print legibly)

Date: _____ Name: _____

Sex: female ❑ male ❑ other ❑
Address:_____City_____
Province: _____ Postal Code: _____ email:_____
Phone: home_____work_____cell_____
Date of Birth:_____ Age:_____
Marital Status: M ❑ S ❑ D ❑ W ❑
Occupation: _____ Employer:_____
Family Physician: _____ Specialists:_____
Emergency Contact: _____ Phone:_____
How did you hear about www.guidingneedleacupuncture.com? friend ❑ relative ❑
health care referral ❑ website ❑ other ❑
From whom?_____

Acupuncture is used worldwide both as a primary & complementary form of medical treatment. Acupuncture truly excels in wellness care. The list of conditions employing acupuncture is essentially limitless. You need not have any complaints to receive acupuncture.

What is your reason for this visit?

_____
_____
_____

What (if any) medical diagnosis have you received:

_____
_____

What (if any) treatments have/are you receiving:

_____
_____

Please list all medications, herbs and supplements you are taking and their dosage:

_____
_____

Are you allergic to any medicines or substances? If so, what?_____

Hospitalization history: (*list as best you can*)

Type of Illness or operation/procedure Date Hospital

_____
_____
_____

_____
_____
_____
_____
_____

Emotional wellness & sleep

How would you characterize your emotional health?

_____

Please check those that you currently experience, and underline those experienced in the past:

❑ Anxiety ❑ Poor memory ❑ Panic attacks ❑ Difficulty concentrating
❑ Depression ❑ Fearfulness ❑ Irritability/anger ❑ Racing thoughts
❑ Confusion ❑ Frequent sighing ❑ Chest tightness ❑ Worry

Are you in a relationship? Yes ❑ No ❑
How do you feel about it?

_____

How do you feel about work? Is it satisfying and rewarding; does it provide you with the necessities of life; is it just a job that you feel you must do in order to make a living? _____

How would you rate your stress level on a scale from 0 - 10?
How do you hold your stress?

_____

How do you relax?

_____

What time do you: Go to bed ____ am/pm Fall asleep ____ am/pm Get up____ am/pm
How many hours of sleep to get? ____ Do you feel refreshed?

_____

I have difficulty: (check any that apply)

❑ Falling Asleep ❑ Staying Asleep ❑ Dream-disturbed Sleep
❑ Recurrent dreams ❑ Nightmares ❑ Waking to urinate, ____ # of times
❑ Waking, with trouble falling back to sleep. What time?

_____

Gastrointestinal

Please check those that you currently experience, and underline those experienced in the past:

❑ Bitter taste ❑ Metallic taste ❑ Sticky taste
❑ Loss of appetite ❑ Gnawing hunger ❑ Belching
❑ Nausea ❑ Vomiting ❑ Heartburn
❑ Indigestion ❑ Vomiting of blood ❑ Ulcers
❑ Acid reflux ❑ Food cravings, _____

Frequency of bowel movements: _____ x per day/week

❑ Constipation ❑ Diarrhea ❑ Irregular
❑ Bloating ❑ Cramping ❑ Burning sensation
❑ Loose stools ❑ Hard stools ❑ Painful to pass
❑ Undigested food ❑ Gas ❑ Pellet-like stools
❑ Mucous in stools ❑ Blood in stools ❑ Strong odour

Fluid metabolism

How much liquid do you consume daily? _____. Are you thirsty? ❑ Yes ❑ No
What temperature of beverages do you prefer? ❑ Hot ❑ Cold ❑ Room temperature
Please check those that you currently experience, and underline those experienced in the past:
❑ Spontaneous sweating ❑ Night sweating ❑ Sweaty palms
❑ Yellow sweating *(can be noticed as stains on armpits and neckline of clothing)*
❑ Frequent urination ❑ Incontinence ❑ Kidney stones
❑ Burning urination ❑ Urinary tract infection ❑ Cloudy urination
❑ Blood in urine ❑ Weak urine stream, or trouble starting

Eyes, ears, nose, throat & head

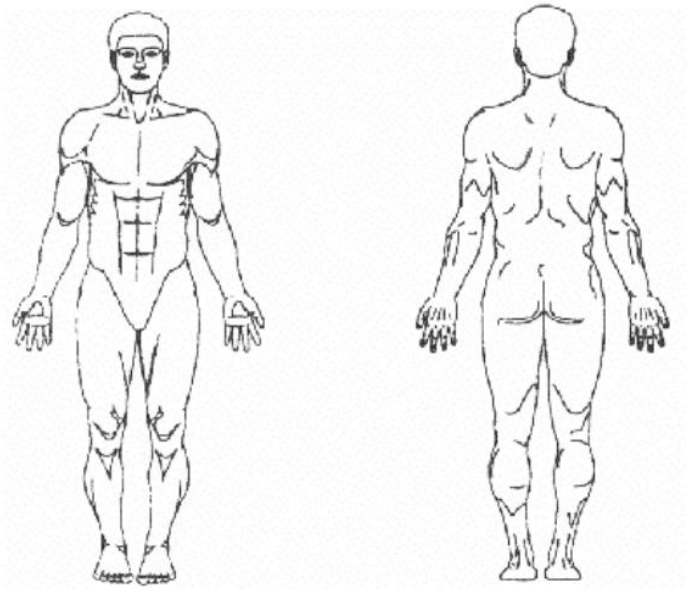
Do you experience headaches/migraines? ❑ Yes ❑ No. How often? _____
Where are these headaches located?
❑ Unilateral ❑ Bilateral ❑ Temples ❑ Behind eye(s)
❑ Occipital/neck ❑ Top of head ❑ Forehead ❑ Whole head
❑ Sinuses ❑ Fixed spot ❑ Moving
What type of pain do they present with?
❑ Burning/stabbing ❑ Dull/achy ❑ Throbbing ❑ Wrapped up feeling
❑ Full ❑ Empty ❑ Stiffness/pulling ❑ Bursting
What makes them better? _____
What triggers or aggravates them? _____
Do you smoke?❑ Yes ❑ No _____ /day for _____ years. Date quit _____
How many times per year do you catch colds/flu's? ____. What kind? *(e.g. common cold, influenza, intestinal flu, or other)* _____
How would you characterize your body temperature? ❑ Hot ❑ Cold ❑ Neither
Does this change at different times of the day? ❑ Yes ❑ No. How? _____
Please check those that you currently experience, and underline those experienced in the past:
❑ Chills ❑ Fever ❑ Alternating chills & fever
❑ Chronic cough ❑ Nose bleeds ❑ Bleeding gums
❑ Canker sores ❑ Cold sores ❑ Dry mouth
❑ Sore throat ❑ Dry throat ❑ Lump in throat
❑ Excessive mucous ❑ Bad breath ❑ Dry eyes
❑ Red/painful eyes ❑ See spots/floaters ❑ Ear pain
❑ Blurred vision ❑ Dizziness/vertigo ❑ Ear ringing
❑ Cataracts ❑ Glaucoma ❑ Facial palsy/tic

Musculoskeletal

What type of pain do you experience? What number best describes your pain now?
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

___ Wandering pain ___ Fixed pain ___ Superficial pain
___ Deep pain ___ Stabbing pain ___ Pricking pain
___ Burning pain ___ Shooting pain ___ Sharp pain
___ Dull pain ___ Aching ___ Gripping pain
___ Numbness ___ Tingling ___ Pins & needles

Locate your pain in the diagrams below, use the letters below to indicate the type and location of your symptoms. KEY: A= ache B= burning N= numbness P= pins & needles S= stabbing X= stiffness T= throbbing O= other



What makes the pain better or worse? (*Mark those factors that make the pain better with a 'B', and those that make the condition worse with a 'W')*
___ Application of cold ___ Application of heat ___ Application of pressure
___ When resting ___ When active ___ When tired
___ When under stress ___ Upon waking ___ In the evening/night
___ Other, please explain
_____

Female reproductive

Please check those that you currently experience, and underline those experienced in the past:
❑ Lumps in breast ❑ Nipple discharge ❑ Breast pain
❑ Pelvic pain ❑ Vaginal discharge ❑ Vaginal itching/burning
❑ Unpleasant odor ❑ Genital eruptions ❑ Painful sex
❑ Lack of sexual desire ❑ Excessive sexual desire ❑ Menstruation absent
❑ Spotting between periods ❑ Clotting in menstruation ❑ Heavy menstruation
Are you sexually active? ❑ Yes ❑ No. Do you use birth control? _____
Have you ever used birth control pills? ❑ Yes ❑ No. How long? _____
Age of first menstruation: ____ Periods occur every ____days, and last _____ days.
Are your periods regular? ❑ Yes ❑ No. Date of last period: _____

Please indicate any of the following that you experience, and underline those that you have experienced in the past. Mark 'B' for before, 'D' for during, and 'A' for after your period.
____ Mood changes ____ Irritability/anger ____ Anxiety
____ Insomnia ____ Crying ____ Forgetfulness
____ Clumsiness ____ Fatigue ____ Dizziness/faint
____ Abdominal bloating ____ Increased appetite ____ Sweet cravings
____ Weight gain ____ Breast tenderness ____ Back pain
____ Cramping ____ Other (*please specify*) _____

Have you had in the past, or do you currently experience problems with fertility? If yes, please explain: _____
_____ # of pregnancies _____ # of births _____ # of miscarriages _____ # of abortions
Any complications of pregnancy? ❑ Yes ❑ No If yes, please explain _____
_____

Male reproductive

Are you sexually active? ❑ Yes ❑ No. Do you use birth control? _____
Please check those that you currently experience, and underline those experienced in the past:
❑ Vasectomy ❑ Prostate problems ❑ Male infertility
❑ Painful erection ❑ Difficult/premature ejaculation ❑ Erectile difficulty
❑ Penile discharge ❑ Swelling, lumps, pain in testes ❑ Other _____
Date of last prostate exam: _____.

Cancellation policy

If you are unable to keep your scheduled appointment, we ask that you let us know as soon as possible so we may schedule another person who needs our services into that time slot. Since we often have a waiting list, a late cancellation means someone else missed out on an appointment. There is a 24-hour cancellation policy for all appointments. A missed appointment will be billed $25.

Patient information consent form

We choose you know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse to give care.
I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Release of liability, waiver of claims, assumption of risks indemnity agreement

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Thomas Nerbas R. Ac
• Acupuncture and other Oriental Medical procedures including diagnostic techniques such as questioning, pulse evaluation, tongue evaluation, abdominal evaluation, observation, range of motion, muscle or orthopedic testing. • Manual or physical therapy including cupping, Tuina, electrical stimulation, infrared heat therapy • The prescription of herbal therapy, dietary supplements, dietary recommendations • Exercise advice and healthy lifestyle counseling.

I, the undersigned, comprehend that acupuncture and related traditional Chinese medicine therapies are given here for the purpose of relieving pain/discomfort and facilitate optimum wellness. I comprehend that no guarantee of cure or improvement in my condition is given or implied. I comprehend all the benefits and risks of these treatments explained by the registered acupuncturist. I comprehend that although these risks are highly unlikely to occur, they are possible. I comprehend that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of needle insertion or radiating from that location, nerve pain, aggravation of current symptoms (healing crisis), appearance of new symptoms, or general aches and pains. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist's judgment during the course of my treatment. I agree to waive any and all claims that I have or may have in the future against the governors of this clinic and its members, officers, employees, agents, volunteers and independent contractors (all of whom are hereinafter collectively referred to as "the releasees)."
To release the releasees from any and all liability for any loss, damage, injury or expense that I may suffer, or that my next of kin may suffer as a result of my participation in the activity of treatments. I freely accept and fully assume full responsibility for any possible adverse effects resulting from these treatments. I have read (or had read to me) this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend 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 from Thomas Nerbas, R. Ac

Signature of Patient _____ Date_____