Initial Patient Intake Form

PLEASE NOTE: If you come across any questions that may be confusing or you do not currently have information for, please highlight them and answer the following questions to the best of your ability. Thank you.

Basic Contact Information:

Today's Date (MM/DD/YY): _____

Full Name: _____

Complete Mailing Address: _____

E-mail address: _____ Phone Number: _____

Gender Identification: _____ Date of Birth (MM/DD/YY): _____ Age: _____

Place of Birth: _____ Number of Years in Canada: _____

Current Living Arrangement (single, married, children etc): _____

Occupation: _____ Number of Hours/Week Worked: _____

Family Physician Name & Phone Number: _____

Emergency Contact Name & Phone Number _____

What is their relation to you? _____

If you are completing this form for another person, what is your relationship to that person?

_____

How did you hear about this clinic? _____

Do you have health insurance that covers Acupuncture? _____

Main Health Concern Information:

What is your Main Health Concern? _____

When did it begin? _____

Was there a specific event that initiated it? (accident, illness etc.), Please explain:

_____

_____

Personal Information:

Do you have any children? If so, how many and their ages? _____

Do you have any blood borne or infectious diseases? _____

Do you currently, or have you ever smoked? If so, for how long? _____

Do you drink coffee? If so, how many per day? _____

Do you exercise? What kind? And how often? _____

_____

_____

Please list any surgery (including cosmetic) you have had: _____

_____

_____

Have you even been hospitalized? Please explain the conditions: _____

_____

Please list any western medications/prescription drugs you are taking (even birth control): _____

_____

_____

Do you have any diagnosis from a Western Medical Doctor? (e.g. low iron or b12, high blood pressure etc.): _____

_____

Please list any supplements/vitamins you are taking: _____

_____

_____

What is your diet like: _____

_____

_____

<u>Overall Body Evaluation:</u> (Please check ALL that apply.)

WOOD ELEMENT (LIVER/GALLBLADDER)

_____ Headaches _____ Migraines _____ Pain in the Rib Areas _____ Cold Hands & Feet

_____Neck/Shoulder Tension _____ Stress _____ Grinding Teeth _____ Jaw Pain _____ Body Pains

FIRE ELEMENT (HEART/SMALL INTESTINE)

_____ Heart Palpitations _____ Anxiety _____ Nervousness _____ Difficult to Fall Asleep

_____ Wake up Often _____ Easy to Fall Asleep _____ Wake up Rested _____ Tired _____ Nightmares

_____ Vivid Dreams _____ Light Sleeper

How many hours of sleep do you get per night? _____

EARTH ELEMENT (SPLEEN/STOMACH)

_____ Gas _____ Bloating _____ Upset/Sensitive Stomach _____ Nausea _____ Acid Reflux

_____ Heartburn _____ Increase/Decrease in Appetite _____ Cloudy Headed/Heavy Headed

_____ Food Allergies If so, what are they? _____

METAL ELEMENT (LUNG/LARGE INTESTINE)

_____ Shortness of Breath _____ Pain in the Chest _____ Stuffy Nose _____ Runny Nose

_____ Frequent Colds _____ Eczema _____ Psoriasis _____ Acne _____ Sensitive Skin _____ Asthma

_____ Allergies If so, what are they? (environmental, seasonal etc.) _____

WATER ELEMENT (KIDNEY/URINARY BLADDER)

_____ Low Back Pain _____ Sensitive/Pain in the Knees _____ Sensitive/Pain in the Ankles

_____ Cold Low Back _____ UTIs/Bladder Infections

How many times a day do you urinate? _____ Do you experience any of the following:

___ Burning with urination ___ Blood in the urine ___ Incontinence ___ Urgency with urination

___ Cloudy urine ___ Urination at Night If so, how many times? _____

BOWEL MOVEMENTS:

How many bowel movements do you have a day? _____ Do you experience constipation? _____

What is your stool generally like? Please check all that apply:

___ Soft ___Loose ___ Diarrhea ___ Undigested Food ___ Blood in Stool ___ Mucus in Stool

GYNECOLOGICAL:

If you remember, please state the age of your first menses (period)? _____

Do you experience any of the following:

_____Clots _____ Painful Periods _____Breast Tenderness _____Endometriosis _____ Infertility

_____ Light Periods _____ Heavy Periods _____ PMS _____ Fibroids _____Cysts

Other: _____

OVERALL HEALTH:

_____ Bleed/Bruise Easily _____ Blurry Vision _____ Blurry Vision at Night _____ Dry Skin / Hair / Nails

_____ Dizziness _____ Sweat Easily _____ Night Sweats

What is your overall body temperature? (more hot/more cold) _____

Do you feel thirsty/dry mouth? _____ How much water do you drink a day? _____

What temperature of liquids do you prefer? (hot/cold/warm/room temp.) _____

How is your appetite generally? _____

What are your main food cravings? _____

Other: _____

FAMILY MEDICAL HISTORY:

Please state if **you or an immediate family member** has experienced any of the following conditions:

___ Diabetes ___ HIV/AIDS ___ Cancer ___ Arthritis ___ Asthma ___ Stroke ___ Menstrual Issues

___ Seizures ___ Kidney Disease ___ Liver Disease ___ Hepatitis ___ Lung Disease

___ Allergies ___ Thyroid Disease ___ Heart Complications ___ High/Low Blood Pressure

Other / Notes: _____

_____

_____

Thank you for taking the time to complete this form.

We will be with you shortly.

Acupuncture & Traditional Chinese Medicine
Disclosure Statement & Informed Consent

I _____, hereby request and consent to Acupuncture and any form of Traditional Chinese Medicine treatments (Cupping, Gua Sha, Massage, Moxabustion) for my stated health concern.

I have been informed that acupuncture is a safe method of treatment, however one may experience some discomfort including pain, dizziness, bruising, or numbness. Unusual and rare risks of acupuncture include nerve damage, organ puncture, infection, premature birth, or miscarriage. Other side effects and risks may also occur. If I suspect I am pregnant, I will inform Amrit Singh immediately. I also authorize this consent form to cover the duration of my treatments with Amrit Singh.

I have discussed the nature and purpose of my treatment with my practitioner and understand there are no guarantees regarding cure or improvement of the condition. I understand there may be limitations to the treatment and may referred to another practitioner or health care provider that will benefit my treatment if necessary. I understand that I also have the choice to stop, change or modify my treatment plan. I have communicated any known or risk of blood borne infectious diseases I might be carrying.

PRIVACY: All information discussed is strictly confidential, in accordance to the Personal Health Information Protection Act ("PHIPA") of Ontario

INSURANCE: Amrit Singh does not bill insurance for you. We will provide you with a receipt for your insurance company upon request.

APPOINTMENTS: All appointments that are cancelled with less than 24 hours notice and missed will be charged $65.00. I as the client agree to pay in full for all of my Acupuncture treatments at King West Chiropractic. I am aware of the fees posted at King West Chiropractic for Acupuncture with Amrit Singh R.Ac

I have read or have had read to me the above consent. I also have had the opportunity to clarify any questions about the content and may withdraw treatment at any time. By signing below, I agree to all terms and conditions stipulated by this document. I am aware this form will cover the entire course of treatment for my condition, and any further condition(s) treated with Amrit Singh.

Patient Signature: _____

Practitioner Signature: _____

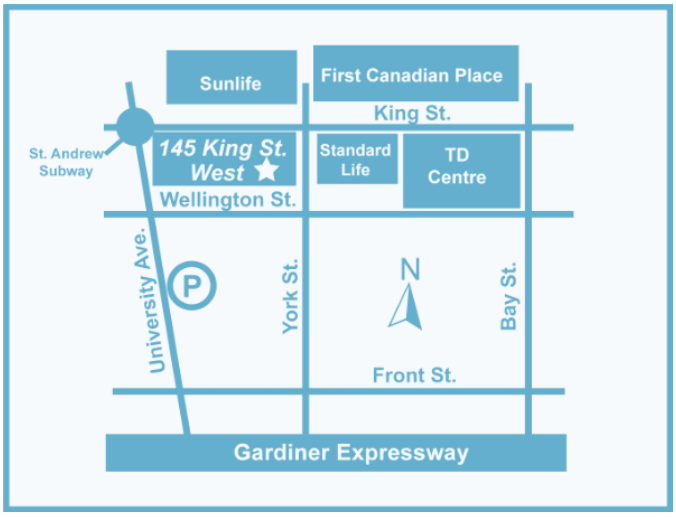
Date: _____

Thank you for booking Acupuncture With Amrit at KWC!

Please review the points below to prepare you for your first visit:

- Your first treatment, including the intake and assessment, will take approximately one hour.
- Payment methods accepted are cash, cheque, VISA/MC (no AMEX or Debit).
- You are clothed and covered during your acupuncture treatment. We can work around the clothing you come in, but please bring shorts and a t-shirt or tank top if possible.
- Please try to eat before your acupuncture appointment. An empty stomach is not ideal for acupuncture.
- Please be respectful of your booking. If you are going to be late, please let us know by calling or texting 416.662.0564. There is also a 24-hour cancellation fee of $65.00 for missing your appointment.
- After your treatment, it's best to have a relaxing day/evening and avoid coffee, alcohol, dairy, sugar or stressful situations and to sleep at a reasonable hour.

Directions to King West Chiropractic:



From St. Andrew Subway Station:

From the subway, exit the turnstiles, pass the convenience stand towards the SUN LIFE doors, and continue down the hall on the right (JUST before the Sun Life doors with the blue tiled walls). This leads you to the concourse level of our building (145 King St. West). Continue past the food court, The Sushi Shop, Zoom Optical and we are located just before Oaken Financial (across from the escalators).

Thank you!

If you have any questions, please contact Amrit Singh R.Ac at 416.662.0564 or book@acupuncturewithamrit.com