

Back to Health
**CHIROPRACTIC
AND WELLNESS**

PATIENT INFORMATION

Full Name: _____ Date of Birth (mm/dd/yy): _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (home) _____ (work) _____ (cell) _____

Occupation: _____ Marital Status: _____ Sex: _____

Emergency Contact: _____ Phone Number: _____

E-mail: _____

How did you hear about us? _____

FAMILY PHYSICIAN

Name of Family Physician: _____ Phone: _____

Medical Centre/Office Location: _____

Date of last visit: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____ Cell: _____

PRIMARY HEALTH CONCERNS

Please list your primary health concerns/chief complaints:

Of which of these concerns is the most important to you? _____

MEDICAL HISTORY AND INFORMATION

Heart disease _____ Y/N HBP _____ Y/N High Cholesterol _____ Y/N Pacemaker _____ Y/N
Blood Thinners _____ Y/N Seizures _____ Y/N Electrical Implants _____ Y/N Pins _____ Y/N

Allergies

Please list any allergies you may have: _____

Medications

Please list all medications you are currently taking including vitamins, herbal and illicit:

Please list how often you smoke and/or use alcohol:

Hospitalizations/Surgeries

Please list to the best of your ability the times you have been hospitalized and illness/procedure:

WOMEN:

Pregnant now: YES NO UNKNOWN

Indicate number of Occurrences:

Live Births _____ Pregnancies _____ Miscarriages _____ Abortions _____

Menstrual Cycle:

Frequency: _____ Flow (Normal/Heavy/Light) _____ Clotting _____

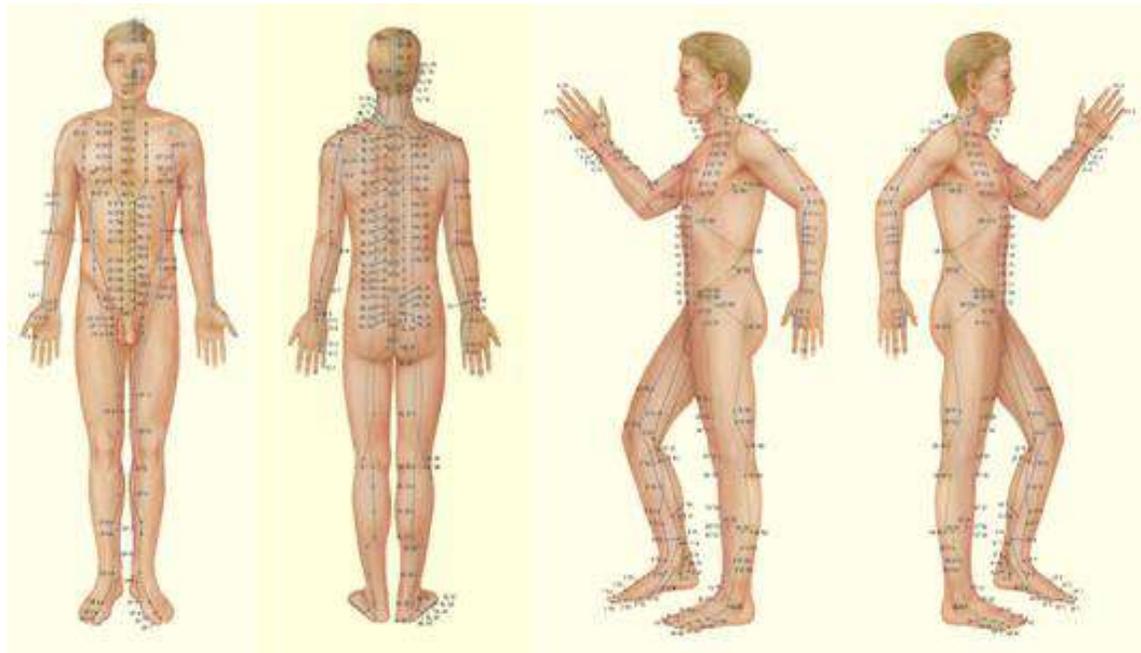
Age of Menopause _____ (if applicable)

Blood Borne, Insect Borne and Sexually Transmitted Diseases

Due to the use of needles below the skin, please check if you are experiencing any of the following. *Any misinformation can result in termination of treatment, among legal complications.*

- | | | |
|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Malaria | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Pelvic Inflammatory Disease | |

Please mark any areas where you experience pain on the figures below with an X:



How would you describe the pain? (please circle all that apply):

dull/achy
pins&needles
burning

sharp/stabbing
electric
fixed in one spot

tingling
numbness
moving around

CONFIDENTIAL ACUPUNCTURE HEALTH INTAKE FORM – Page 4

Please circle all that pertain to you:

Qi

general tiredness
 lack of morning energy
 weakness of limbs
 spontaneous sweating
 poor appetite
 hunger w/o desire to eat
 loose stools
 dislike of speaking
 discomfort in abdomen
 chest distension
 depression
 frequent sighing
 feeling of lump in throat
 inability to digest fats

Blood

dizziness
 palpitations
 dull complexion
 numbness and tingling
 weak muscles
 muscle cramps
 poor memory
 blurry vision
 floaters in vision
 dry eyes
 pale lips
 white nails
 difficulty staying asleep

Body Fluids

dry Mouth, nose, lips, eyes
 cracked lips
 dry cough
 dry Skin
 hoarse voice
 lack of sweating
 scanty urination

Elimination

dark urine
 scanty urine
 blood in stool
 blood in urine
 abundant clear urine

Lung (LI/Metal)

shortness of breath
 asthma
 cough
 sinus problems
 environmental allergies
 no sense of smell
 skin problems
 fear
 expectoration of phlegm
 rattling sound with voice
 nose bleeds

Liver (GB/Wood)

distention in the ribs
 irritability
 outbursts of anger
 breast distention
 sour regurgitation
 hiccups/belching
 mouth ulcers
 eye problems
 gallstones
 headaches
 stress
 timidity
 anxiety
 craving sour food
 dream disturbed sleep
 ringing in ears (high pitch)

Stomach (SP/Earth)

excessive thirst
 lack of thirst
 sticky taste
 bleeding gums
 foul breath
 excessive hunger
 borborygmous (stomach growling)
 burning sensation in stomach
 loose stool
 vomiting
 heartburn
 nausea
 prolapse
 racing thoughts
 craving sweet food
 edema
 difficulty getting to sleep
 mental restlessness
 food allergies
 over-thinking
 odorous sweat

Yin/Yang

hot body temperature
 cold body temperature
 preference for hot drinks
 preference for cold drinks

Heart (SI/Fire)

palpitations
 high blood pressure
 low blood pressure
 bleeding gums
 shortness of breath on exertion
 Pale complexion
 tongue ulcers
 stuffiness in the chest
 cold hands
 stabbing chest pain
 sadness
 craving spicy food

Kidney (UB/Water)

low back pain
 knee problems
 weak or cold legs
 decreased libido
 impotence
 infertility
 night sweating
 tinnitus (low pitch)
 metallic taste in mouth
 deafness
 hot flashes
 feelings of heat in palms or feet
 depression
 lack of initiative
 craving salty food
 waking to urinate
 dark urine
 scanty urine
 blood in stool
 blood in urine
 abundant clear urine
 dribbling after urination

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Traditional Chinese Medicine. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, guasha, herbal therapy, tuina (chinese massage).

I am hereby informed that the aforementioned treatment methods are all generally safe but there may be some side effects or risks, as follows:

1. Acupuncture may potentially cause temporary bruising, swelling, bleeding, tingling or soreness at the sight of needling. Unlikely, risks of acupuncture, include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although, only sterile, disposable needles are used within a clean safe environment.
2. Potential risks of moxibustion, cupping and guasha are temporary bruising, blisters and redness lasting a few days.
3. The herbal and nutritional supplements are generally safe in the traditionally recommended doses. The herbs/nutritional supplements are for *you* and not for anyone else. Possible side effects of herbs include, nausea, flatulence, stomachache, headache, and skin eruptions. If I experience any of the above symptoms I must stop taking the herbs and notify your practitioner.
4. I will notify the practitioner should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.
5. I understand that I can discuss the risks and benefits further before signing, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise her judgement in my best interest during the course of treatment, based upon the facts known.
6. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment.
7. After receiving acupuncture treatment you might feel a little lightheaded (and sometimes euphoric). Please feel free to have a seat, drink a little water and relax to let yourself come back to normal.
8. All fees are payable at the time of your treatment.
9. If you must miss an appointment, please let this office know at least 24 hours prior to your scheduled appointment. Failure to do so may result in a missed appointment fee equal to the cost of the appointment.
10. I give consent to allow my file to be shared with all practitioners within the Back to Health clinic if necessary.

Patient Name

Patient Signature

Date

Witness Name

Witness Signature

Date

Subscriber Enrollment

As an extension of the care you receive in our practice, may we add you as a subscriber to our website that will help you...

**Get Well
and
Stay Well.**



First name : _____ Last name : _____

Date of birth : ____ / ____ / ____

Email address : _____

Naturally you can unsubscribe at any time.
