

# New Patient Intake Form

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Marital Status \_\_\_\_\_ Age \_\_\_\_\_  
Month Day Year

Address \_\_\_\_\_ Sex  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_

City, Province, Postal Code \_\_\_\_\_ Occupation \_\_\_\_\_

Home Ph.# \_\_\_\_\_ Work Ph.# \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Emergency contact name & ph. # \_\_\_\_\_ E-mail \_\_\_\_\_

Referred by \_\_\_\_\_ Have you ever had acupuncture?  Yes  No

How did you hear about the clinic? \_\_\_\_\_ Have you ever had Chinese herbal medicine?  Yes  No

Reason for visit today \_\_\_\_\_

Primary health concerns & complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_

Does it bother you:  Sleep  Work  Other (what?) \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Are you under the care of a physician now?  Yes  No If yes, for what? \_\_\_\_\_

Who is your physician? \_\_\_\_\_ Physician's Ph. # \_\_\_\_\_

Is this condition related to an accident or injury at work?  Yes  No

If yes, please provide WCB claim # \_\_\_\_\_ Case manager's name & ph. # \_\_\_\_\_

Other concurrent therapies \_\_\_\_\_

Do you have any contagious diseases at this time? (Hepatitis, H.I.V., T.B., Influenza etc.)  Yes  No

If yes, please list: \_\_\_\_\_

## Show area(s) of pain or unusual feeling.

Mark the areas on the body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

- Numbness            ● ● ● ●

                          ● ● ● ●

                          ● ● ● ●
- Pins & Needles    ○ ○ ○ ○

                          ○ ○ ○ ○

                          ○ ○ ○ ○
- Burning             X X X X

                          X X X X

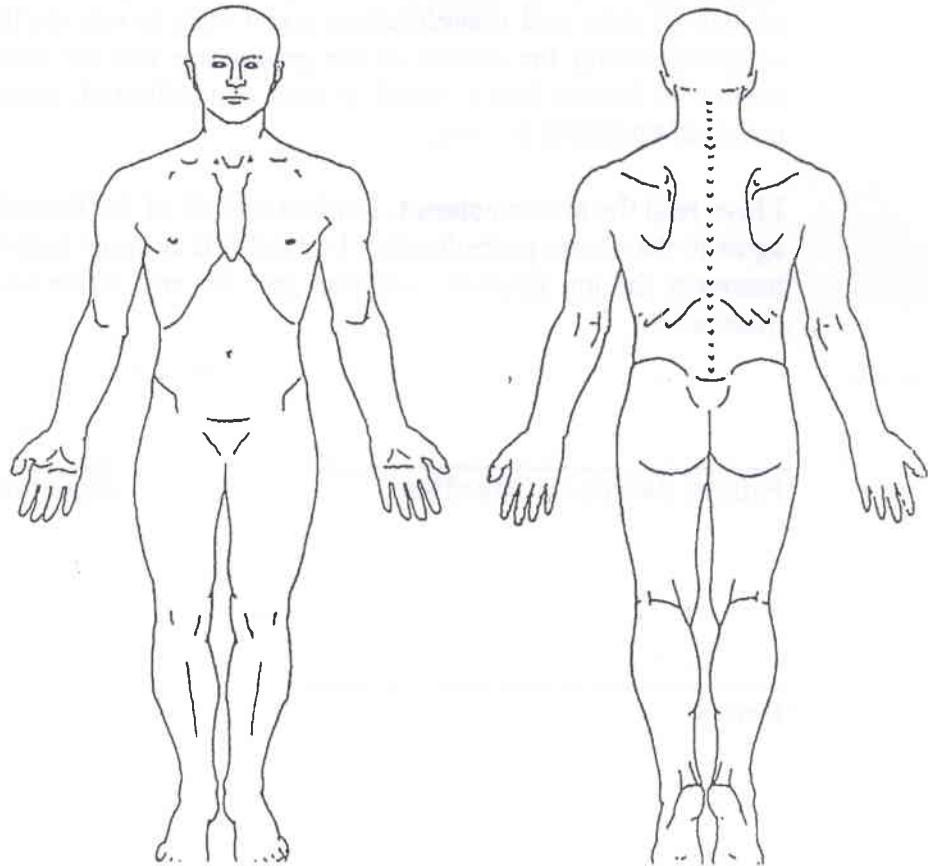
                          X X X X
- Aching              A A A A

                          A A A A

                          A A A A
- Stabbing            / / / /

                          / / / /

                          / / / /



## Informed Consent

# PLEASE READ CAREFULLY

### Informed Consent for Acupuncture Care

I, \_\_\_\_\_ do hereby voluntarily request and consent to be treated with Acupuncture and other procedures related to Acupuncture including needling, moxibustion, cupping, gua sha, laser, electroacupuncture or any other techniques within the scope of practice of acupuncturists. These procedures may be performed by the registered Acupuncturist named above.

I have had the opportunity to discuss with the registered Acupuncturist the nature and purpose of Acupuncture care and other procedures. 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 Acupuncture treatment at any time.

I further understand and am informed that, as in all health care, in the practice of Acupuncture, even though all needles are pre-sterilized and disposable, there are some risks to treatment including but not limited to temporary soreness or discomfort, bruising, blistering, nausea, fainting, bleeding, infection, shock, and possible temporary aggravation of symptoms. 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 to exercise judgment during the course of the procedures that he feels are in my best interest. I consent to having blood tested in case of needlestick accident at any time during my course of treatment in clinic.

I have read the above consent. I understand all of the foregoing, and by signing below I agree to the above procedure(s). 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.

\_\_\_\_\_  
Patient, Parent or Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date