Women's Balance Health

Acupuncture Intake Form

Date: _____

Name: _____ Birthday: ___/___/___ Age: ____ Male ▫ Female ▫
(Last) (Middle) (First) (dd/ mm/yy)

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

Address:
_____
(Street) (Apt/Suite #) (City) (Postal Code)

Email: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone #: _____

Reason for Visit

_____ Have you previously had: ▫ Acupuncture ▫ Chinese Medicine

Current health care providers

Family Physician: _____ Phone number: (___)_____

Western Medical diagnosis (if applicable): _____

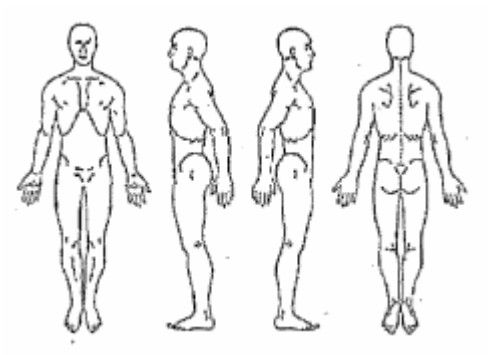
Other medical treatment received: ▫ Fertility Clinic ▫ Physiotherapy ▫ Massage ▫ Naturopath ▫ Chiropractor ▫ Other _____

Health Overview

Please indicate with 'P' (past) 'C' (current) 'F' (family) if any of these conditions apply:

	Heart condition		Stroke		High /Blood Pressure		Low Blood Pressure
	Diabetes		Deep Vein Thrombosis		Neurological		Spinal or head injury
	Respiratory conditions		Kidney Disorder		Cancer		Hepatitis
	HIV/AIDS		Sprain/Strain/Fracture		Osteoporosis		Headaches/Migraines
	Jaw Pain		Arthritis		Dizziness/Fainting		Contagious Illness
	Skin Condition		Digestive Problems		Hemophiliac		Pacemaker
	Lung Condition		Epilepsy		Possibility of Pregnancy		Upcoming surgeries

On the figures below, please circle areas of concern/pain:



Sensations/pain characteristics (check all that apply):

Sharp ☐ Burning ☐ Moving ☐ Tingling ☐ Dull ☐

Severe ☐ Stabbing ☐ Shooting ☐ Throbbing ☐

Numbness ☐

What relieves the pain (ice, rest, activity, massage, heat…)?

_____

What aggravates the pain (weather, heat, cold, rest, activity…)?

_____

Please list any prescription medication or over the counter drugs currently taking:

1. _____
2. _____
3. _____
4.. _____

List all herbal medicines or supplements currently taking.

1. _____
2. _____
3. _____
4.. _____

Please list any allergies (food, drugs, environmental, etc):

1. _____
2. _____
3. _____
4.. _____

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Lifestyle

How often do you consume:

Caffeine _____ Added salt _____
Pop _____ Artificial sweeteners _____ Sugar _____
Alcohol _____ Recreational drugs _____ Tobacco _____

Do you participate in the following physical activities? If so, please indicate how often:

☐ Yoga ☐ Running ☐ Fitness Class ☐ Gym ☐ Biking

☐ Swimming ☐ Walking ☐ Other

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan

___ Irritability / frustration / impatient
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / Dry / Itchy eyes
___ Headaches / Migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin

___ Palpitations
___ Chest pain / tightness
___ Insomnia / Sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen

___ Frequent urination
___ Bladder infection
___ Lack of Bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei

___ Dry cough
___ Cough with Phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi

___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased Thirst
___ Prefer Warm / Cold drinks
___ Sweat easily

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation?
Do you enjoy work?
How many hours per week do you work?
Is your job stressful?
What are your duties?

Are your bowel movements regular?
How many times per day/week?
Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention?
What color/shade of yellow is it?
Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken Antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

How did you hear about our clinic?

□ Phone book □ Walked by the clinic □ Clinic website
□ Print advertising □ Brochure □ Facebook □ Referral by: _____

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and
maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot
anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects
can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good
- sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally
- considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Women's Balance Health, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Women's Balance Health (also, Women's Balance Health will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on Women's Balance Health premises. On occasion, Women's Balance Health may use client/patient information to conduct clinical studies to help us improve upon services provided.

_____ _____

Print name in full Signature

(Print name of representative if represented by another) (Signature of Representative)

_____

Date

Appointment Policy

Welcome to Women's Balance Health. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability.

A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid a cancellation fee of $40.

This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Any questions regarding my appointments have been addressed.
I have read this statement and fully understand it.

Print Name _____ Date _____

Signature _____

Patient Information Release Request Form

I, _____ (please print name) give full consent so that Women's Balance Health may consult freely with other physicians and healthcare professionals (of which whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

(to be filled out by your practitioner)

The following is an authorization to provide Women's Balance Health with the following information:

□ All recent lab work results

□ All medical records

□ All semen tests

□ Other: _____

I am eighteen years of age or older:

□ Yes □ No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable):_____

Thank you for your prompt attention to this request. If you have any questions, please feel free to contact us.