Eaglewood Chiropractic Health Centre

105 Dartmouth Road
Bedford, NS, Canada, B4A 2L8
Tel: (902) 422 - 6688 Fax: (902) 860 - 6688

Who may we thank for referring you?: _____

Name: _____ _____ Date: _____

Mailing Address: _____

Home Tel: _____ Work Tel: _____ Cell: _____

Email: _____ Health Card #: _____

Birthday: _____ Gender: _____ Marital Status: _____

Occupation: _____ # Children (Ages): _____

Alternate Contact: _____ Tel: _____

Family Doctor: _____ Tel: _____

Health Goals and Concerns:

What brought you to the clinic today? _____

How long have you had it? _____

What makes it better? _____

What makes it worse? _____

Your stress level? (1 – Lowest; 10 – highest) _____ Your energy level? (1 – Lowest; 10 – highest) _____

Pain and Tension:

Do you feel pain now? Please rate it (1 – Lowest; 10 – highest)_____

Is the pain? ☐ sharp ☐ aching ☐ burning ☐ shooting ☐ dull ☐ tingling ☐ numb

Where is it? _____

What makes it better? ☐ heat ☐ cold ☐ exercise ☐ rest ☐ acupuncture ☐ massage ☐ chiropractic ☐ physio

Diet and Digestion:

Allergies and/or food sensitivities: _____

Do you ever have indigestion after eating or stomach pain, discomfort, nausea, vomiting? If so, please describe: _____

List of foods you avoid: _____

Do you have thirst? _____ How much liquid do you drink per day? _____

Do you prefer hot or cold drinks?_____

Do you have any of the following?

☐ diarrhea ☐ loose stools ☐ dry stools ☐ constipation ☐ irregular or absent bowel movements

☐ straining ☐ alternating diarrhea/constipation ☐ bloating ☐ gas ☐ bad breath

How many bowel movements do you have per day: _____

Urination:

How many times do you urinate per day: _____ Is your urine: ☐ clear ☐ light yellow ☐ dark

Do you have: ☐ profuse urine ☐ scanty urine ☐ interrupted flow? A kidney and/or bladder infection? ☐

Is it difficult or painful to urinate? _____ Do you wake at night to urinate? _____

Head, Chest and Breathing:

Do you experience any of the following? ☐ phlegm (Please describe)_____

☐ shortness of breath ☐ sinus problems ☐ vertigo ☐ difficulty breathing ☐ palpitations

☐ chest pain/discomfort ☐ asthma/wheezing ☐ bronchitis ☐ chronic cough ☐ emphysema

Skin and Sweat:

Do you experience any of the following? ☐ sweat easily ☐ sweaty hands & feet ☐ profuse sweat

☐ acne or boils ☐ dry skin ☐ easily bruised ☐ sweat at night ☐ rashes ☐ eczema

☐ psoriasis ☐ other skin conditions _____

Temperature:

Do you experience any of the following?

☐ cold hands ☐ cold feet ☐ Other areas cold: _____

☐ hot hands ☐ hot feet ☐ Other areas hot: _____

☐ fever ☐ chills ☐ alternating fever and chills ☐ aversion to cold ☐ aversion to heat

Neurological, Vision and Hearing:

Do you experience any of the following? ☐ loss of consciousness ☐ blackouts ☐ generalized pain

☐ headaches or migraines ☐ nervousness ☐ convulsions ☐ dizziness ☐ fainting

☐ ringing or buzzing in ear ☐ hearing loss ☐ numbness ☐ tingling ☐ nausea

☐ problems speaking ☐ blurred vision ☐ eye pain ☐ fibromyalgia

Cardiovascular / Endocrine:

Do you have any of the following? ☐ blood clots ☐ jaundice ☐ ulcer ☐ diabetes

☐ bleeding disorders ☐ hardening of the arteries ☐ previous heart attacks ☐ high blood pressure

☐ poor circulation ☐ swelling of the ankles ☐ phlebitis or varicose veins ☐ low blood pressure

☐ kidney disease ☐ previous stroke ☐ chronic congestive heart failure

☐ heart disease ☐ irregular heart beat ☐ pacemaker or similar device

☐ any other heart or blood disease, or contagious diseases _____

Family History:

Has anyone in your family been diagnosed with any of the following conditions? ☐ high or low blood pressure

☐ heart disease ☐ asthma ☐ eczema ☐ pelvic inflammatory disease ☐ respiratory disorders

☐ osteoarthritis ☐ cancer ☐ epilepsy ☐ kidney disease ☐ psoriasis ☐ mental illness

☐ fibromyalgia ☐ depression ☐ thyroid disorder ☐ rheumatoid arthritis ☐ circulation problems

☐ multiple sclerosis ☐ diabetes ☐ neurological disorders ☐ headaches or migraines

Emotions:

Do you frequently feel: ☐ anger ☐ frustration ☐ sadness ☐ joy ☐ worry ☐ depression

Sleep:

How easy is it for you to fall asleep? _____ Do you feel rested when you wake? _____

Do you wake up in the night? If so, what wakes you? _____

For Men:

Have you had a recent physical exam? _____ Any prostate conditions? _____

Do you have or ever had any urinary infections or STDs? _____

Do you experience any of the following? ☐ feeling of coldness or numbness in external genitalia

☐ swollen testes ☐ impotence ☐ testicular pain ☐ premature ejaculation ☐ prostate problems

For Women:

Age of first period: ___ Number of Pregnancies: _____ Number of children: ____ Any Miscarriages? _____

Are you pregnant now? _____ Is your menstrual cycle regular? _____ Average days of cycle? _____

How long does your period last? _____ Is the flow: ☐ Heavy ☐ Light ☐ Normal

What color is the flow? ☐ bright red ☐ pale red ☐ dark red ☐ purple ☐ brown

Are there clots? If so, what color and size are the clots? _____

Do you experience any of the following pre-menstrual symptoms?

☐ breast tenderness ☐ vomiting ☐ alternating diarrhea/constipation ☐ food cravings

☐ headache ☐ migraines ☐ depression ☐ irritability ☐ anxiety

Do you get abdominal cramping? If so, is the cramping better with: ☐ pressure ☐ heat ☐ exercise

Do you bleed between periods? _____ Have you ever had abnormal pap smears? _____

Do you experience vaginal: ☐ dryness ☐ irritation ☐ pain ☐ itch ☐ discharge

Did you have any of the following? ☐ yeast infection ☐ chlamydia ☐ pelvic inflammatory disease

Age of last period: ___ Any symptoms related to menopause? _____

The Chinese Medicine and Acupuncture Association of Canada

L'Association de Medecine Chinoise et D'Acupuncture du Canada

加拿大中醫藥針灸學會

Patient Informed Consent to Treatment

1. I understand that some of the techniques used under the scope of practice for Traditional Chinese Medicine include the use of sterile single use needles to penetrate the skin. Other methods could also include but not limited to: electrical stimulation of the needles, acupuncture, acupressure, cupping or moxibustion, gua sha, therapeutic massage/Chinese Tuina Massage, or Shiatsu.

2. My practitioner has informed me of the risks and temporary symptoms of the treatments, which can include, but are not limited to: light-headedness, soreness, bruising, bleeding or discoloration of the skin. I freely accept the risks involved with my procedure.

3. I agree to inform the practitioner of any health concerns or conditions I currently have or develop, if I suffer from a bleeding disorder, use a pacemaker or are pregnant.

4. I understand that I am obligated to inform my practitioner if I am carrying any infectious diseases, including but not limited to HIV, TB and Hepatitis. If cross contamination risk is too high, treatment may be refused.

5. I understand that there are no guarantees for the result of the treatments. Traditional Chinese Medicine does not often provide instant cure or relief. The length of treatment and frequency depends on the severity of my condition. In some cases symptoms may appear to worsen before they show improvement.

6. I understand the fee structure and that fees are not covered under MSI. Fees must be covered in full by myself or after through submission of receipts of a third party insurance. I am responsible for full and prompt payment after services have been rendered.

7. I agree to expose certain areas of my body (e.g. hip areas) for facilitating acupuncture treatment.

I have discussed the content of this consent form and had all my questions answered. By signing this form, I give my informed consent for Traditional Chinese Medicine/Acupuncture Treatments.

_____
Name (Please Print)

_____
Signature of patient (or legal guardian)

Date: _____

_____
Signature of Practitioner

Date: _____