TCM PATIENT INTAKE FORM

FULL NAME: _____

DATE OF BIRTH: _____

Address_____

City:_____ **Postal Code**_____

Phone Home _____ **Cell**_____

E-Mail Address _____ **Occupation**_____

Would you like to receive our Source Centre Email Newsletter? YES NO

Emergency Contact _____ **Phone #**_____

Family Physician: _____

Family Physician's phone:_____

Family Physician's Diagnosis: _____

Reason for Today's Visit:_____

How did you hear about us?: _____

Your Treatment Goals: _____

Have you had Acupuncture Before? YES NO

MEDICAL HISTORY

Have you seen a physician in the past 5 years? YES NO If so, when?: _____

Are you currently taking medication including Herbs and Supplements? If so please list them.

_____

Are there any areas of your body that cause you pain or concern? Please describe:_____

_____

Do you currently have or have you ever had any of the following? Circle Y (YES) or N (NO).

AIDS
Alcoholism
Allergies
Anemia
Arthritis
Asthma
Cancer
Deep Vein Thrombosis Diabetes
Jaw Pain
Kidney Disease/Stones
Liver Conditions
Mental Illness
Migraines or Headaches
Multiple Sclerosis
Osteoporosis
Pacemaker

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Digestive Disorders
Drug Addiction
Emotional Disorder
Epilepsy
Fibromyalgia
Gall Stones
HIV
Heart Condition
Hemophilia
Hepatitis
High/Low Blood Pressure
Respiratory Condition
Rheumatic Fever
Sinus Problems
Skin Conditions
Spinal Injury
Sprains or Fractures
Stroke
Thyroid Problem
Tuberculosis
Ulcers
Ulcerative Colitis

Other (Please Specify): _____

Do you currently or have you ever experienced any of the following? (please circle)

Shortness of Breath Night Sweats

Lifestyle:

Describe your diet? _____

_____

Do you crave any particular foods?_____

Do you exercise? Yes No
How often? _____ Type? _____

Stress Level: Low – 1 2 3 4 5 6 7 8 9 10 - High

Sleep: Hours per night _____ Rested in AM? _____

Trouble falling asleep? _____ Trouble staying asleep? _____

Do you get up to urinate more than once? _____

Work:

Enjoy work? Yes No
Hours per week working: _____

Hobbies: Yes No
Describe:_____

Please indicate the use and frequency of the following:

Coffee: Yes No

How Much _____

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Tobacco: Yes No

How Much _____

Alcohol: Yes No

How Much _____

Recreational drugs: Yes No

Which drugs: _____

How Much and how often?: _____

Have you ever been a smoker? Yes No
For how long and how much did you smoke? _____

Symptom Survey (please circle)

0 = never, 1 = rarely, 3 = frequently, 2 = occasionally, 4 = always

0	1	2	3	4	low appetite	0	1	2	3	4	ravenous appetite
0	1	2	3	4	loose stools	0	1	2	3	4	heartburn/refulx
0	1	2	3	4	gas/abdominal bloating	0	1	2	3	4	mouth sores
0	1	2	3	4	fatigue after eating	0	1	2	3	4	belching/vomiting
0	1	2	3	4	hemorrhoids	0	1	2	3	4	gums bleeding/swollen
0	1	2	3	4	bruise easily	0	1	2	3	4	thirst Hot? Cold?
0	1	2	3	4	anemia	0	1	2	3	4	bad breath

0	1	2	3	4	abnormal sweating	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	tired after little exertion
0	1	2	3	4	shortness of breath	0	1	2	3	4	general weakness
0	1	2	3	4	cough	0	1	2	3	4	nasal discharge
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	sinus congestion

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0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feel cold often
0	1	2	3	4	low back pain	0	1	2	3	4	swollen ankles
0	1	2	3	4	frequent urination	0	1	2	3	4	poor memory
0	1	2	3	4	urinary incontinence	0	1	2	3	4	hair loss
0	1	2	3	4	ear/hearing problems	0	1	2	3	4	infertility
0	1	2	3	4	early morning diarrhea	low		normal			high libido

0	1	2	3	4	irritable	0	1	2	3	4	muscle spasms/twitches
0	1	2	3	4	ligament/tendon issues	0	1	2	3	4	numb extremities

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0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry, irritated eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	sigh frequently	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes

0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	restlessness
0	1	2	3	4	anxiety	0	1	2	3	4	palpitations

0	1	2	3	4	dizzy upon standing	0	1	2	3	4	feeling of heat
0	1	2	3	4	see floaters in eyes	0	1	2	3	4	nausea
0	1	2	3	4	heat in palms or soles	0	1	2	3	4	foggy thinking
0	1	2	3	4	afternoon fever	0	1	2	3	4	enlarged lymph nodes
0	1	2	3	4	night sweats	0	1	2	3	4	cloudy urine
0	1	2	3	4	frequently flushed face						

Urination: (Circle all that apply) Burning Urgent Scanty

Difficult Profuse Dribbling More than 1x a night

Bowel Movements: Frequency _____

Consistency (circle): well-formed, hard, loose, alternates between formed and loose

Do you ever notice any undigested food, blood or mucous? _____

Are you thirsty? Yes No If so, do you crave warm or cold drinks? _____

Upon waking, do you have a bitter taste in your mouth? _____

Do you find that you “run” particularly hot or cold? _____

How is your energy in general? _____

Do you often get headaches or migraines? Yes No

How do you feel emotionally right now? _____

_____

Women Only:

Are you currently pregnant? _____ Are you on the birth control pill? _____

# of pregnancies_____ # of live births_____ # of miscarriages_____ # of abortions_____

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How old were you when you had your first period? _____

Have you experienced menopause? Yes No If yes, when? _____

If you are experiencing menopausal symptoms, please describe: _____
_____

Vaginal Discharge? Yes No Clear/White/Yellow/Green Itch/Burn/Pain/Foul Odor

Is your period regular?_____ When was the first day of your last period?_____

# of days from the start of one period to the start of the next _____

Average number of days of flow: _____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Purple

Blood clots? Yes No

Do you get pain or cramps? Yes No Low Back/Low Abdomen

Nature of pain (circle): Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?
Water retention Breast tenderness/swelling Depression Irritability Migraines
Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

Men Only:
Date of last prostate check up: _____ Results: _____

Circle all that apply: Groin pain Decreased libido Testicular pain Impotence

Migraines Night sweats Painful urination Difficult urination Dribbling urination

Incontinence Premature ejaculation Nocturnal emissions Increased libido

_____

To the best of your knowledge, is there any medical condition that you have not disclosed?

YES NO

If yes, please clarify: _____

_____

_____

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Consent to Treatment

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

While acupuncture, Chinese medicine and the other treatments provided at this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. You should be aware that the following side effects can occur.

- **Drowsiness can occur in some small number of patients, if so, we recommend that you do not drive.**
- **Minor bleeding or bruising can occur from acupuncture.**
- **In less then 3% of patients, symptoms may worsen for 1-2 days before improving. Please advise your practitioner if symptoms worsen for more than 2 days.**
- **Fainting can occur in certain patients, particularly at the first treatment.**

I, the undersigned, consent to receive treatment offered by Dr. Sarah Vincent, Naturopath. I also acknowledge full responsibility for payment of services. I, the undersigned, certify that all of the above medical history provided is true to the best of my knowledge, and I have not knowingly omitted information.

Patient Name (Please Print): _____

Signature of patient: _____

Name of Consenting (Under 18 Yrs) _____

Signature of Consenting (Under 18 Yrs) _____

DATE SIGNED: _____/_____/_____/
DAY MONTH YEAR

SOURCE CENTRE
FOR HEALTH & WELLNESS

SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms. http://www.sourcecentre.ca/about/more/terms-service/

SOURCE CENTRE
FOR HEALTH & WELLNESS

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have a bout the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

If the above client is under the age of 16 years, and/or an infirm dependent, please fill out below:

Signature _____

Client Name _____ Date_____

Signature of parent or Guardian (for anyone under the age of 18):

Signature _____

Guardian/Parent Name _____ Date_____