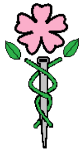


Wildrose
Community
Acupuncture

Health Intake Form

Patient Information

Name ________________________
Address ______________________
City __________________________
Postal Code___________________

Preferred Phone (H/W/C) _________________
Alternate Phone (H/W/C) _________________
Email ________________________

Emergency Contact
Name _____________________
Relationship _______________
Phone (H/W/C)______________

Today's Date: ______________________________
Age ______ Birthdate (MMDDYY) ___________
Primary Physician __________________________
Physician phone number ___________________
Date of last physical ________________
AB Health Care #: ___________________

Occupation __________________
Company ____________________

How did you hear about the clinic?
☐ Phonebook ☐ Passing by ☐ Friend
☐ Relative ☐ Other: ________________

Health History

What are your primary concerns for treatment?

1. ___________________________
2. ___________________________
3. ___________________________

Please list any other health care practitioners you have consulted for these concerns: ______________
____

List medications and food supplements you are taking. _____________________________
____

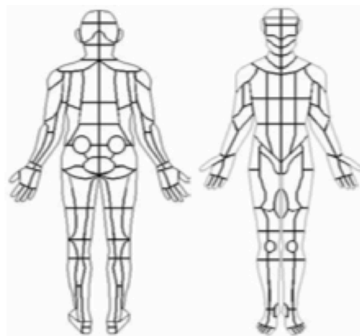
Please indicate any areas where you have:

Pain / Aching / Sharp / Stabbing
Numbness / Tremors
Cramps / Swelling
Radiating / Stiff
Tight / Sore

Severity:
On a scale of 1-10:

Time of day:

Aggravating factors:



Please indicate if you have experienced any of the following conditions:

Cancer / Heart Disease / High Blood Pressure

Hemophilia / Other Blood Disorders / Stroke

HIV/AIDs / Hepatitis / Epilepsy / Diabetes

Fibromyalgia / Communicable Disease

Allergies: ______________________________

Other Conditions: ______________________

List serious illnesses, accidents, or surgeries.
____
____

Check illnesses that have occurred in blood relatives

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Kidney disease

Health History Continued

Please indicate any symptoms you have or have had in the last year:

Respiratory System
Cough / Asthma / Wheezing / Difficulty breathing / Frequent colds / Persistent cough / Hay fever
Allergies

Digestive System
Cravings / Excessive appetite / Indigestion / Nausea / Poor appetite / Reflux / Vomiting / Ulcer
Difficulty swallowing / Eating Disorder / Food sensitivities

Sleep
Difficulty: falling asleep – staying asleep – waking up / Dream disturbed sleep
Hours of sleep/night: ______ / Do you feel rested when you wake up? Yes/No

Head, Neck, & Throat
Headaches / Migraines / Blurred vision / Contact lenses, glasses / Cataracts / Glaucoma / Earache
Eye pain / Gum trouble / Nose bleeds / Loss of hearing / Ringing in ears / Sinus problems

Neurological
Depression / Anxiety / Panic Attacks / Learning disability / Alzheimer's / Parkinson's / Mental illness
Epilepsy

Chest and Abdomen
Chest pain / Palpitations / Hardening arteries / High or low blood pressure / Previous heart attack
Rapid or irregular heart beat / Abdominal pain / Bloating / Hernia / Diverticulitis / Liver or
Gallbladder disease

Urinary system and Bowel Movements
Colon trouble / Constipation / Diarrhea / IBS / Distention of abdomen / Gallbladder trouble
Hemorrhoids / Blood or pus in urine / Frequent urination / Inability to control urine / Kidney disease
Urinary Tract Infection

Reproductive
Infertility / Bleeding between periods / Clots in menses / Excessive menstrual flow / scanty menstrual
flow / Menstrual pain / Irregular cycle / Menopausal symptoms / PMS / Previous miscarriage
Fibroids, ovarian cysts / Pelvic Inflammatory Disease /Erection difficulties / Penis discharge
Prostate problems / High or Low libido / STD
Could you be pregnant? ___________

Other
Arthritis / Muscle aches, cramps / pins-plates-prosthesis / Swelling-inflammation / Fever / Chills
Cold-hot hands-feet / Osteoporosis / Dry skin / Itchy skin / Rash / Sensitive skin / Sore won't heal
Bruise easily / Daytime sweats / Night sweats

Lifestyle
Smoking (_____/day) / Alcohol (_____/week) / Drug addiction / Caffeine (coffee, tea, pop) / Water
(______glasses/day) / Exercise description: ____
Diet: ____

Informed Consent for Acupuncture Care

Please read all points on this form. If you have any questions concerning this consent form, feel free to discuss these with the acupuncturist. Please initial next to each paragraph that you have read and understood said paragraph. If you have any questions regarding treatment, your therapist will discuss these with you.

________ All information provided will be held in the **strictest confidence** unless upon receipt of a **written** request along with a signed release from the client. ALL or PART of the client's records can be released to the client, or the client's personal representatives:

a) Lawyer; b) Insurance companies; c) other health care professional; d) others.

________ Payment for treatments is due upon completion of treatment. All fees are payable in cash, with cheque, debit card, Visa or Mastercard. Direct billing is available with certain insurance providers; please inform our staff if you wish to have us check for the availability of your coverage.

Fees:	New Patient Acupuncture	$30.00
	Acupuncture	$20.00

________ In Community Acupuncture, you are not requested to disrobe. You may be asked to roll up your pants to your knees, and your sleeves up to your elbows. Some needling locations around the neck and upper chest may be used which require moving the neckline of your shirt.

- A client has the right to refuse, modify or terminate treatment at any time.
- A therapist has the right to refuse, modify or stop treatment at any time if there is a reasonable cause.

______ I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxibustion, cupping, gua sha, and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the acupuncturists or another duly authorized person in the clinic.

_______ I have had the opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that results are not guaranteed.

_______ I have been advised that all inserted needles are pre-sterilized and disposable. I further understand and am informed that as with all health care, the practice of acupuncture poses slight risks from treatment, including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection, and shock. 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 which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

Please indicate if you are interested in receiving emails of the following nature:

_______ Appointment reminders (please note, if you book your appointments online you will already receive appointment reminders via email)

_______ Newsletters featuring clinic updates, upcoming events, and information relating to acupuncture or community acupuncture.

Section 8(1) of Alberta's Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless:

a) That person has already consulted with a physician or, in the case of dental pathology, a dentist about the condition for which care and treatment from the acupuncturist is being sought;
b) That person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and
c) The acupuncturist has completed a patient consultation form.

NAME OF ACUPUNCTURIST:
Lindsay Babcock or Stephanie Hosker
Wildrose Community Acupuncture
5024 50 St
Camrose, Alberta T4V 1R2

PATIENT SIGNATURE: _____________________________________ **NAME (please print):** ____

PARENT/GUARDIAN SIGNATURE:____________________________________ **NAME (please print):** ___________________________________

Date of Consultation with Acupuncturist: ______________________________________