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BACK & BODY HEALTH

Acupuncture New Patient Intake Form Date:

Please complete all fields below as accurately as possible, even if you feel they do not pertain to your condition. The information on this form is confidential and will be used for no other purpose other than to ensure proper treatment. Please inform us of any changes in the future.

Name:_____Contact Number:_____

Alternate Contact Number:(h/w/c) _____

Mailing address: _____

City: _____ Postal Code:_____

Date of Birth: (m/d/y)_____ Email: _____

Emergency Contact (name and number): _____

Occupation and work activities:_____

Marital Status:_____Do you have any children or dependents? Y / N _____

Activities/Hobbies:_____

How did you hear about our clinic and Dr. Nunes?_____

Have you ever had Chinese herbs or experienced acupuncture before? Y / N, How long ago?_____

For what condition?_____ From what type of practitioner?_____

Have you consulted a physician with regards to the problem(s) you are here for? Y / N When? _____

Primary Physician:_____Phone number:_____

Are you pregnant or planning to become pregnant? Y / N Due Date: _____

Have you been in a motor vehicle accident? Y / N Date: _____Medical Doctor:_____

Before your treatment please make sure that you:

- are neither hungry nor full, it is best to have a small meal or snack an hour or so before your treatment
- are not under the influence of alcohol or drugs
- are not dehydrated
- wait at least ½ hour after moderate or intense physical activity, do not plan for physical activity afterwards
- inform Dr. Nunes if you are feeling any strong emotions or anxiety the day of your appointment
- do not brush your tongue the day of treatment
- bring a short sleeve shirt and either shorts or loose fitting pants to change into

Main problem(s) you would like addressed with acupuncture?

Please include: when the problem(s) began, was there anything going on in your life at the time that it started, how often it occurs, how severe is it, anything that alleviates or worsens the condition, and any other pertinent details.

Medical History:

Any major traumas/accidents, illnesses and/or surgeries:

Please check all that apply:

___AIDS/HIV	___Alcoholism/Substance Abuse	___Thyroid Disorder	__Cancer
___Hepatitis A / B / C	___Multiple Sclerosis	___Varicose Veins	___Epilepsy/Seizures
___Diabetes	___High/Low Blood Pressure	___Pacemaker	___Gout
___Heart Attack/Stroke	___Compromised Immunity	___Heart Disease	___Tuberculosis

Medications and supplements (please list name, reason and dosage):

Allergies:

Family Medical History:

Daily Life:

How would you rate your day to day (or weekly) stress level? And what is/are the primary source(s)?

Do you have a regular exercise program? Please describe:

How is your energy? Low 1 2 3 4 5 6 7 8 9 10 High

When do you have the most and least energy? Most_____ Least_____

Do you fatigue easily? Y / N Does physical exertion increase your fatigue or energize you?_____

Do you experience spikes and/or crashes in your energy levels? Y / N When? _____

Do you frequently experience (check all that apply):

__ Sadness / Depression __ Anxiety / Nervousness __ Easily Irritated __ Anger / Frustration

__ Mood Swings __ Poor Memory __ Poor Concentration __ Restlessness

Please indicate consumption of:

Coffee or tea: ____cups/day Water: ____cups/day Alcohol: ___glasses/week Soft Drinks: ____cups/d or wk

Do you smoke? Y / N, How much? _____Are you trying to or would like to quit? Y / N, Any recreational drugs?

Please describe your daily eating habits:

How many hours per night do you sleep? _____ Do you feel rested upon awakening? Y / N

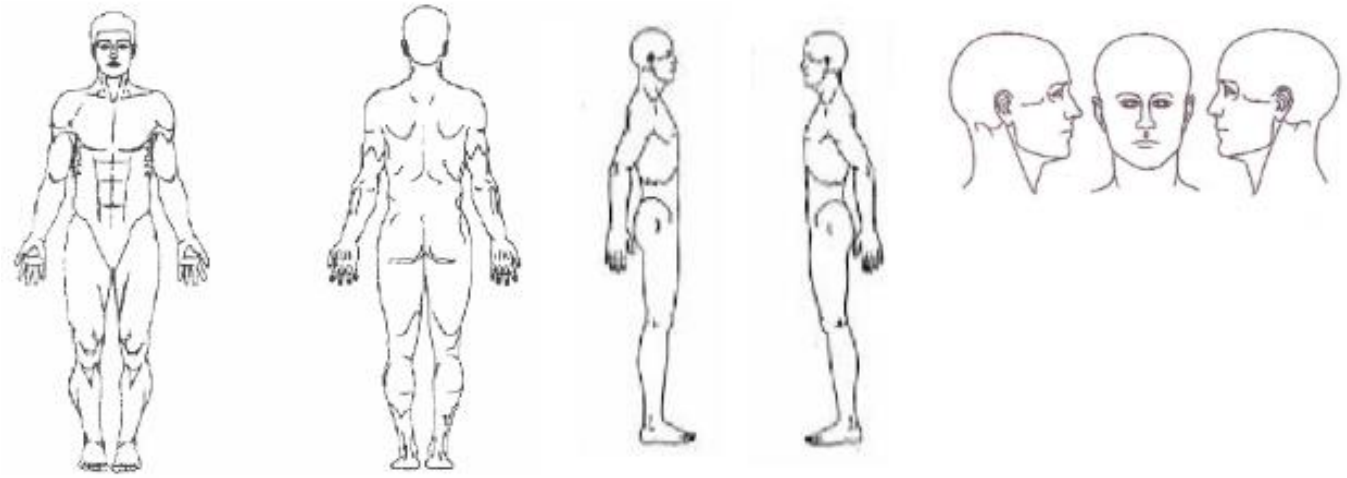
Do you have any issues with: (please check all that apply)

__ Falling Asleep __ Staying Asleep __ Dream Disturbance __ Difficulty Waking Up

__ Falling Back Asleep __ Restlessness __ Waking to Urinate __ Night Sweats

Muscles, Bones and Joints:

Do you have any pain, tightness or distress? None 1 2 3 4 5 6 7 8 9 10 Extreme For How Long?_____



The Pain or Tightness is: (please check all that apply)

__ Sharp __ Dull __Aching __ Numb __ Superficial

__ Burning __ Tingling __ Shooting __ Sour (lactic acidlike) __ Deep

__ Fixed __ Moves Around __ Intermittent __ Continuous __ Worse at Night

What makes the pain/discomfort worse? Better?

Do you have (check any that apply):

__ Swollen Joints __ Arthritis/Joint pain __ Tendonitis __ Muscle Cramping

__ Chronic pain __ Repetitive Strain Injury __ Bone pain __ Fractured Bones

For the following sections please check all that apply, and use P if it was an issue more than 3 months ago and is no longer a concern.

General
___ Insomnia
___ Dreams/ nightmares
___ Irritability
___ Depression
___ Mood swings
___ Fatigue
___ Poor memory
___ Strongly like cold drinks
___ Strongly like hot drinks
___ Recent weight loss/gain
___ Cold hands & feet
___ Chills
___ Fever

Head & Neck
___ Headaches
___ Migraines
___ Stiff neck
___ Dizziness
___ Fainting
___ Swollen glands

Ears
___ Ringing
___ Hearing loss
___ Infections
___ Earache
___ Hearing aids
___ Vertigo

Eyes
___ Glasses/ contact lenses
___ Blurred vision
___ Poor night vision
___ Spots or floaters
___ Eye inflammation
___ Double vision
___ Glaucoma
___ Cataracts
___ Droopy Eyelids

Nose, Throat & Mouth
___ Sinus infection
___ Frequent sore throat
___ Difficulty swallowing
___ Mouth & tongue ulcers
___ Frequent colds
___ Nosebleed
___ Dry nose
___ Nasal congestion
___ Loss of voice
___ Thirst
___ Excessive phlegm
___ TMJ
___ Facial pain
___ Gum problems
___ Dry mouth

Skin
___ Hives
___ Rashes
___ Eczema/ psoriasis
___ Night sweating
___ Excess sweating
___ Dry skin
___ Easy bruising
___ Changes in moles, lumps
___ Itching

Respiratory
___ Difficulty breathing
___ Difficulty breathing when lying down
___ Wheezing
___ Asthma
___ Chronic cough
___ Wet cough
___ Dry cough
___ Coughing up phlegm
___ Coughing up blood
___ Shortness of breath
___ Tight chest
___ Pneumonia

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Chest pain or tightness
___ Palpitation
___ Rapid heart beat
___ Irregular heart beat
___ Poor circulation
___ Swollen ankles
___ Phlebitis
___ Anemia
___ History of heart attack

Gastrointestinal
___ Nausea
___ Indigestion
___ Stomach pain
___ Diarrhea
___ Constipation
___ Poor appetite
___ Excessive hunger
___ Vomiting
___ Gas
___ Hiccups
___ Acid regurgitation
___ Bloating
___ Bad breath
___ Laxative use
___ Bloody stool
___ Mucus in stool
___ Hemorrhoids
___ Gall Bladder disorder

Musculoskeletal
___ Joint pain/Arthritis
___ Swollen Joints
___ Chronic Pain
___ Tendonitis
___ Bone Pain
___ Muscle Cramping
___ Repetitive Strain Injury
___ Fractured Bones
___ Sore muscles
___ Weak muscles
___ Difficulty walking
___ Neck/shoulder pain
___ Upper back pain
___ Lower back pain
___ Rib pain
___ Limited range of motion
___ Other (describe)

Neurological
___ Seizures
___ Tremors
___ Numbness or tingling
___ Pain
___ Paralysis
___ Poor coordination
___ Other (describe)

Genito-urinary
___ Pain on urination
___ Frequent urination
___ Urgent urination
___ Blood in urine
___ Unable to hold urine
___ Incomplete urination
___ Bedwetting
___ Wake to urinate
___ Increased libido
___ Decreased libido
___ Kidney stones
___ Impotence
___ Premature ejaculation
___ Nocturnal emission
___ Pain/itching of genitalia
___ Lumps in testicles

Allergies
___ Food
___ Airborne
___ Digestive
___ Animal Related
___ Seasonal
___ All Year Long

Other

Women Only:

___ Age of First Menstruation
___ Amenorrhea (no menstruation) If so:
Have you had periods before?
If so, when did they stop?
___ Birth Control. If so which brand and for how long? Any issues while taking birth control?

Any profuse or abnormal vaginal discharge? Please describe:

Is your cycle regular? Y / N ___ Number of days of entire cycle. How many days on average do you bleed? _____
If irregular, is there any pattern? Y / N, Please list menstruation start and stop dates of last 4 cycles Start Date
End Date

Pre Menstrual Symptoms: (even if you are no longer menstruating)
B – before menses, **D** – during menses, **A** – after menses, for all that apply (even if you are no longer menstruating)

___ Water retention	___ Cravings	___ Fatigue	___ Nausea
___ Headaches/Migraines	___ Breast Tenderness	___ Breast Swelling	___ Vomiting
___ Pain:	___ Cramps:	___ Anxiety	___ Changes in Sleep
Location:	Location:	___ Irritability	___ Changes in Skin Issues
Sharp / Dull / Shooting	Severity:	___ Mood Swings	___ Change in Mental Function
Severity:		Other Emotions:	

Menstruation: (Please check or circle all that apply, even if you are no longer menstruating)

___ Heavy Flow (start / end)	___ Clots:	Colour:	Consistency:
Number of days: ___	Thick / Thin	___ Light red/ Fresh red	___Thin or runny
___ Light Flow (start / end)	Large / Small	___ Dark red / Deep red	___ Thick
Number of days: ___	Dark / Light / Any mucous?	___ Brownish red	___ Sticky
Any unusual smell? Y / N	Any pain with clots? Y / N	___ Brown/ Black	___ Mucous

Pregnancy, Childbirth and Menopause:

___ Number of Pregnancies
___ Number of Miscarriages
___ Number of Abortions
___ Number of Births

What type of birth and were there any issues:

___ Are you pregnant or trying to become pregnant?
___ Having difficulty becoming pregnant
___ Would your partner be interested in co-treatment
___ Age of Menopause (if applicable, start & end)
___ Any change in libido or sexual function?
___ Do you still experience cyclical symptoms? Y / N

Men and Women:
Are there any other things you would like to discuss?

Informed Consent Form

Please read carefully and sign. If you have any questions please don't hesitate to ask us.

I _____ consent to acupuncture treatments and related procedures associated with TCM (Traditional Chinese Medicine) on myself (or the patient named below, for whom I am legally responsible), by Philippa Nunes BASc, RAc, DTCM, henceforth referred to as my Acupuncturist. I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, tui-na, electrical stimulation, Chinese herbology and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, and that it may have minor side effects, including but not limited to light headedness, slight bruising, slight bleeding, numbness or tingling near the needling sites that may last a few days, and in rare cases fainting, aggravation of current symptoms (healing crisis), appearance of new symptoms, or general aches and pains, there is a risk of punctured organs however this is extremely rare when receiving acupuncture from a qualified acupuncturist.

I will notify my Acupuncturist should I become pregnant or if I am trying to become pregnant as certain acupuncture protocols and herbs are contraindicated (while other TCM treatments are favourable). I understand that bruising is a common response to cupping and gua sha treatments and lasts 1 – 5 days. Burns and scarring are potential risks of moxibustion. I will inform my Acupuncturist if I have any condition and/or am taking any medication that interferes with blood clotting. I will notify my Acupuncturist if I have a pacemaker as electrical stimulation is contraindicated. This office uses sterile, disposable needles and maintains a clean and safe environment.

The herbs and herbal formulas that are used are traditionally considered safe in the practice of TCM and ongoing research continues to support this. If I experience any allergic reactions to the herbs I will stop taking them and immediately inform my Acupuncturist. I understand that some herbs may be inappropriate during pregnancy. I will notify my Acupuncturist should I become pregnant, am breastfeeding or if I am trying to become pregnant. Herbal prescriptions and herbal patent medicines are intended only for the person for whom they were dispensed.
I do not expect my Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on my Acupuncturist to exercise judgment during the course of the procedure which my Acupuncturist feels, based on facts then known, is in my best interests.

I understand that by Law in Alberta, acupuncturists do not diagnose illness, disease, or any physical or mental disorders, nor do they prescribe medical treatment or pharmaceuticals. I acknowledge that acupuncture is not a substitute for medical examination or diagnosis, and that if I have not already seen a physician for that service I will do so within two weeks. I have stated all medical conditions that I am aware of and will update my Acupuncturist of any changes in my health status. _____ (initials)

I understand the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent. I agree to receive email communication from my Acupuncturist in regards to appointments, clinic updates, and general communication with my acupuncturist. By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I have been informed about the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. Although I am aware that Acupuncture and the other TCM procedures have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

_____ _____

Signature of patient or guardian if patient is under 18 years | Date

_____ _____

Signature of Therapist | Date