New Patient Intake Form

Lendrum Health Centre. 5846-111 Street. Edmonton, AB. T6H 3G1

			Date: / /	
First Name:	Last Name:	Date of Birth: / /	Age:	Sex:
Address:	City/Province:	Postal Code:	Ph(H):	
Occupation:	Marital Status: S M D W	E-Mail:	Ph(W):	
AHC:	How did you hear about us?		Ph(C):	

Have you had Acupuncture before? ☐ Yes ☐ No Have you had Chinese Herbal Medicine before? ☐ Yes ☐ No

Please describe your Current Health Concern: ______

When did the problem begin? ______ What were you doing at the time? ______

What makes it worse? ______

What makes it better? ______

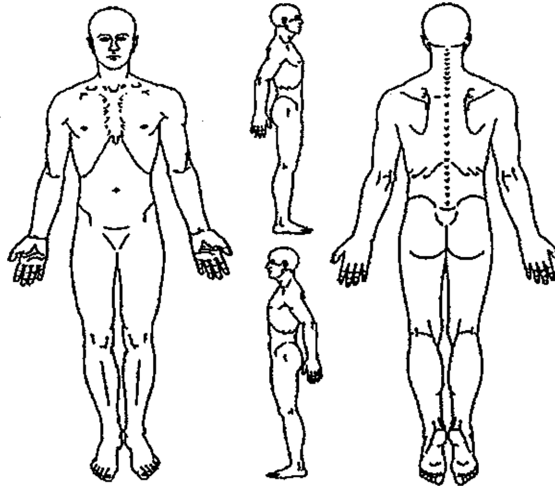
Describe the feelings associated with this Concern:

☐ Health Check ☐ Sharp Pain ☐ Dull Pain ☐ Throbbing ☐ Burning
☐ Weakness ☐ Aching ☐ Shooting ☐ Numbness ☐ Tingling

How frequent is it? ☐ Constant (100%) ☐ Frequent (>50%) ☐ Occasional (25-49%) ☐ Intermittent (<25%)

How would you describe the intensity now: 0 1 2 3 4 5 6 7 8 9 10

Please use these diagrams to indicate the main area of concern as well as any other areas of pain, stiffness, discomfort or injury in your body:



Are your symptoms: ☐ Increasing ☐ Decreasing ☐ Not Changing

Have you been treated for this concern before? ☐ Yes ☐ No By who? ______

What did they do? ______ What was the outcome of that care? ______

Are you under the care of a physician now? ☐ Yes ☐ No Physician's Name and number: ______

Are you using any other types of therapies? ☐ Yes ☐ No If so, please provide details: ______

Physical Stress

Have you had any surgeries? ☐ Yes ☐ No When and for what? ____________________

Have you had any Trauma/injury/fractures? ☐ Yes ☐ No Explain? ____________________

When was your last x-ray? What was it for? ____________________

Please list all major illnesses you've experienced: ____________________

____

Please list any prolonged postures or positions you hold your body in for extended periods, past or present. ____________________

____

How do you grade your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible

Chemical Stress

Please list all medications/supplements you are currently on: ____________________

____

Please list any allergies you may have: ____________________

Do you now or have you ever smoked cigarettes? ☐ Yes ☐ No ☐ Never

Briefly describe your diet (meat and vegetables, vegetarian, artificial sweeteners, refined foods, health supplements/natural remedies)

____

How many cups of coffee/tea do you drink per day? ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8+

How many glasses of water do you drink per day? ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8+

How many glasses of alcohol do you drink per week? ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8+

Emotional Stress

Please list current emotional stresses (work, relationships, health concerns, financial, etc).
Please Rate them on a scale of 1-10.

Emotional Stress	Rating

How do you grade your emotional health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible

Family Medical History

(Please tick all applicable and provide details of family member where possible)

☐ Allergies (please provide details): ____________________

☐ Cancer (please provide details): ____________________

☐ Arteriosclerosis ☐ Heart Disease ☐ High blood pressure ☐ Low blood pressure

☐ Stroke ☐ Seizures ☐ Asthma ☐ Diabetes ☐ Alcoholism

Other than already mentioned, do you have or experience any of the following symptoms or conditions? (please tick all applicable)

Digestion

- ☐ Poor Appetite
- ☐ Heavy Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ Gas
- ☐ Irritable Bowels
- ☐ Constipation
- ☐ Diarrhea
- ☐ Laxative Use
- ☐ Bloating
- ☐ Rectal Pain
- ☐ Intestinal Pain/ Cramping
- ☐ Hemorrhoids
- ☐ Strong Odor Stools
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Mucous in Stools

Sleep/ Skin

- ☐ Fatigue
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Restless Sleep
- ☐ Lack of Strength
- ☐ Cold Hands/ Feet
- ☐ Varicose Veins
- ☐ Bruise Easily
- ☐ Nosebleeds
- ☐ Ulcerations
- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Hair Loss
- ☐ Itching
- ☐ Fungal Infections
- ☐ Athletes Foot
- ☐ Warts

Eyes/ Head/ Respiratory

- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Spots in Eyes
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ TMJ Pain
- ☐ Tooth/ Gum Pain
- ☐ Bleeding Gums
- ☐ Mouth Sores
- ☐ Sore Throat
- ☐ Asthma
- ☐ Shorth of Breath
- ☐ Sinus Problems
- ☐ Phlegm
- ☐ Dry Mouth

Ears/Brain/ Stress

- ☐ Poor Hearing
- ☐ Ringing in Ears
- ☐ Earaches
- ☐ Loss of Balance
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Poor Memory/ Focus
- ☐ Seizures
- ☐ Numbness
- ☐ Tremors
- ☐ Cramps
- ☐ High Stress
- ☐ Anxiety
- ☐ Irritability
- ☐ Depression

Circulatory

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Dizziness
- ☐ Rapid Heartbeat
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Throbbing Leg Pain
- ☐ Slurred Speech
- ☐ Fever/ Chills
- ☐ Excess Perspiration
- ☐ Night Sweats
- ☐ Hot Flushing

Genito-Urinary

- ☐ Frequent Urination
- ☐ Incomplete Urination
- ☐ Urgent Urination
- ☐ Wake to Urinate
- ☐ Pain on Urination
- ☐ Blood in Urine
- ☐ Strong odor in Urine
- ☐ Kidney Stones
- ☐ Increased Libido
- ☐ Decreased Libido
- ☐ Impotence
- ☐ Premature Ejaculation

Gynecological

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Missed Periods
- ☐ Clots
- ☐ Cysts
- ☐ PMS symptoms
- ☐ Breast Lumps
- ☐ Breast Tenderness

Length of last cycle:
Date last period began:

Pregnancies:
Live Births:

Age at Menopause:
Menopausal Symptoms:

Is there anything else about your health or life circumstances which you think may be relevant? ______________

____

INFORMED CONSENT

I hereby request and consent to receive Massage Therapy from a Registered Massage Therapist in this office. I agree to Communicate with my Massage Therapist in order to build a treatment plan that will suit me.

I understand that Massage Therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, improve body awareness, increase sense of well-being, and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

____________________	____________________	____________________
PATIENT NAME	PATIENT SIGNATURE	DATE

I understand that there is a cancellation fee for missed appointments with less than 24 hours notice ____________________

please initial

INFORMED CONSENT

I hereby request and consent to performance of Acupuncture treatment and other procedures within the scope of Traditional Chinese Medicine (TCM) on me (or the patient named below, for whom I am legally responsible) in this office.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counselling.

I have had the opportunity to discuss with the Acupuncturist the nature of Acupuncture and Traditional Chinese Medicine. I understand that results are not guarnateed.

I undertand that there are some minor risks attendant to Acupuncture treatment, including, but not limited to, slight bruising of the skin (hematoma) and/or slight bleeding. I understand that slight bruising is common response to cupping and gua sha treatments. 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. I will notify my Acupuncturist should I become pregnant or am trying to become pregnant, as certain acupuncture protocol is contraindicated, while other TCM treatments are favorable.

I do not expect the Acupuncturist to anticipate and explain all risks and complications, and I wish the Acupuncturist to exercise judgement during the course of the procedure which he/she feels is best in my interest.

I understand the clinical and administrative staff 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.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned proceduresе. I intend this consent form to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment.

About your Treatment

1. Sometimes after receiving and acupuncture treatment, you may feel a little light-headed. If this occurs, please sit for a while in the waiting room. In a few minutes, you will feel fine.

2. Herbal prescriptions and Herbal patent medicines are intended ONLY for the person for whom they were dispensed.

PATIENT NAME	PATIENT SIGNATURE	DATE

I understand that there is a cancellation fee for missed appointments with less than 24 hours notice ______

please initial