高山
SHAN WELLNESS

New Patient Intake Form

Information Confidential: Please Print Clearly

Date: dd/mm/yy

Name: _____ Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Sex: ☐ Female ☐ Male Birthday (dd/mm/yy) _____ Age ____

Address: _____ City/Town: _____ P.C. _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Occupation: _____

Reason for today visit: _____

_____

Your family physician's diagnosis (if available): _____

Are you taking any prescription or over the counter medications? (Please List):

_____

For what conditions?: _____

Are you taking any nutritional or vitamin supplements ? (Please List:) _____

How did you hear about Acupuncture and Traditional Chinese Medicine being offered at this clinic?: _____

_____

MEDICAL HISTORY

What forms of treatment or therapy do you currently use?

☐ M.D. (Name and Phone Number) _____ _____

☐ Physiotherapist ☐ Massage Therapist ☐ Chiropractor ☐ Naturopath

☐ Other: _____

Have you had acupuncture before? ☐ Yes ☐ No

Have you been prescribed traditional Chinese medicinals? ☐ Yes ☐ No

Please indicate, by filling in the boxes, which, if any of the following health conditions below apply to you:

P = PAST C=CURRENTLY F= FAMILY HISTORY

☐ AIDS/HIV	☐ Alcoholism	☐ Tuberculosis
☐ Birth Trauma	☐ Asthma	☐ High/Low Blood Pressure
☐ Diabetes	☐ Cancer	☐ Deep Vein Thrombosis
☐ Epilepsy	☐ Respiratory Disorder	☐ Neurological Condition
☐ Hepatitis	☐ Heart Condition	☐ Spinal or Head Injury
☐ Polio	☐ Herpes	☐ Kidney Disorder
☐ Scarlet Fever	☐ Pacemaker	☐ Sprain/Strain/Fracture
☐ Stroke	☐ Rheumatic Fever	☐ Osteoporosis
☐ Osteoarthritis	☐ Seizures	☐ Headaches
☐ Jaw Pain	☐ Rheumatoid Arthritis	☐ Dizziness/Fainting
☐ Contagious Illness	☐ Skin Condition	☐ Digestive Problems

Please list any allergies that you may have: _____

_____

Have you been hospitalized or treated for any infectious/serious condition or surgeries?
☐ Yes ☐ No
Briefly describe for what reason or condition you were hospitalized and the year in which your were:_____

_____

Are you scheduled to have any upcoming surgeries ☐ Yes ☐ No
Briefly explain what type of surgery you are scheduled for and for what contition:

Rate your energy level out of 10 (1 = extremely low, 10 extremely high):_____

Diet (please list any specific diet, and the type of food you eat): _____

_____

Glasses Water/Day_____ ☐ Coffee/Tea ☐ Soft Drinks ☐ Artificial Sweeteners

Preferred Flavor: ☐ Sour ☐ Bitter ☐ Sweet ☐ Spicy ☐ Salty

Work: ____ Hrs./Week ☐ Normal Hours ☐ Irregular Hours ☐ Shift Work

How often do you get physical activity?_____

What type of physical activity do you regularly participate in?: _____

_____

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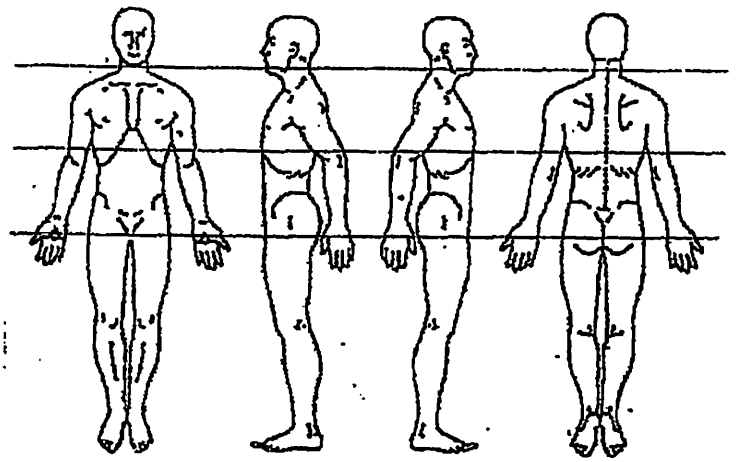
Do you use the following? if so how often?:
Alcohol: _____ Tobacco:_____ Recreational Drugs:_____

Please inform your TCM doctor/acupuncturist if any of the following apply to you:

Epilipsy	☐ Yes	☐ No	Haemophiliac	☐ Yes	☐ No
Wear a pacemaker?	☐ Yes	☐ No	Are you vegetarian?	☐ Yes	☐ No
Have a serious heart or lung condition	☐ Yes	☐ No	Do you have scheduled surgeries?	☐ Yes	☐ No
If you are taking anticoagulant medications	☐ Yes	☐ No	Are you pregnant or is there a chance you may be pregnant?	☐ Yes	☐ No

On the figures below, please draw an "X" over the areas where you have pain or concern:



Sensations/Pain:

☐ Sharp ☐ Burning ☐ Moves ☐ Tingling
☐ Dull ☐ Severe ☐ Shooting ☐ Distending
☐ Numbness

What relieves the pain (hot/cold/massage/rest/exercise,etc.)?

_____

_____

Signature Date: dd/mm/yy

_____ _____

If you are currently experiencing any of the following symptoms, or have been in the past three months, please check the appropriate boxes.

GASTROINTESTINAL (check all that apply):

- ☐ Belching
- ☐ Ulcers
- ☐ Hernia
- ☐ Heartburn
- ☐ Bad Breath
- ☐ Black Stools
- ☐ Intestinal Pain
- ☐ Rectal Pain
- ☐ Nausea
- ☐ Bloating
- ☐ Acid Reflux
- ☐ Gas
- ☐ Loose Stool
- ☐ Bloody Stool
- ☐ Itchy Anus
- ☐ Anal Fissures
- ☐ Vomiting
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Hiccup
- ☐ Constipation
- ☐ Mucous in Stool
- ☐ Burning Anus
- ☐ Other: _____

RESPIRATORY:

- ☐ Chronic Cough
- ☐ Difficult Breathing
- ☐ Cough Up Blood
- ☐ Frequent Colds
- ☐ Short of Breath
- ☐ Other: _____
- ☐ Wheezing/Asthma
- ☐ Cough Up Phlegm

MOUTH, THROAT, AND NOSE:

- ☐ Dry Mouth
- ☐ Nose Bleeds
- ☐ Bitter Taste
- ☐ Swollen Glands
- ☐ Hay Fever
- ☐ Other: _____
- ☐ Thirst
- ☐ Canker Sores
- ☐ Sinus Infection
- ☐ Recurring Sore Throat
- ☐ Difficulty Swallowing/Lump in Throat
- ☐ Prefer Cold Drinks
- ☐ Prefer Hot Drinks
- ☐ Bleeding Gums

HEAD & NECK:

- ☐ Dizziness
- ☐ Enlarged Lymph Nodes
- ☐ Other: _____
- ☐ Fainting
- ☐ Neck Stiffness
- ☐ Headache/Migranes

EYES:

- ☐ Blurred Vision
- ☐ Poor Night Vision
- ☐ Spots/Floaters
- ☐ Other: _____
- ☐ Red/Burning Eyes
- ☐ Dry Eyes
- ☐ Visiual Obstructions
- ☐ Itchy Eyes
- ☐ Eye Pain

EARS:

- ☐ Decreased Hearing
- ☐ Earaches
- ☐ Wax Build Up
- ☐ Recurring Infection
- ☐ Ringing Tone
  - ☐ High ☐ Low

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CARDIOVASCULAR:

- ☐ Palpitations
- ☐ Cold Hands/Feet
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Bruise Easily
- ☐ Varicose Veins
- ☐ Poor Circulation
- ☐ Low Blood Pressure
- ☐ Anemia
- ☐ Chest Pain/Tightness
- ☐ Spider Veins
- ☐ Irregular Heart Beat
- ☐ High Cholesterol
- ☐ Hemophilia
- ☐ Swollen Ankles
- ☐ Other: _____

UROGENITAL:

- ☐ Kidney Stone
- ☐ Bedwetting
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Pain or Itching of Genitalia
- ☐ Decreased Libido
- ☐ Wake to Urinate
- ☐ Blood in Urine
- ☐ Painful Urination
- ☐ Increased Libido
- ☐ Unable to hold urine
- ☐ Excess or Scanty Urination
- ☐ Genital Discharge
- ☐ Other: _____

MUSCULOSKELETAL:

- ☐ Backache or Knee Pain
- ☐ Spinal Curvature
- ☐ Body Aches/Stiffness
- ☐ Bodily Heaviness
- ☐ Difficulty Walking
- ☐ Joint Pain
- ☐ Tingling/Numbness
- ☐ Weakness
- ☐ Other: _____

DERMATOLOGICAL:

- ☐ Hot Flashes
- ☐ Changes in moles/lumps
- ☐ Oily Skin
- ☐ Itching
- ☐ Rashes
- ☐ Nails Break Easily
- ☐ Bruise Easily
- ☐ Spontaneous/Easily Sweat
- ☐ Acne
- ☐ Hives
- ☐ Thinning Hair/ Falling Out
- ☐ Dryness
- ☐ Night Sweats
- ☐ Eczema/Psoriasis
- ☐ Rosacea
- ☐ Other: _____

APPETITE:

- ☐ Healthy/Normal
- ☐ Need to Eat Several Meals
- ☐ Ravishing Hunger
- ☐ Hunger, but no desire to eat
- ☐ Poor Appetite

SLEEP:

- ☐ Sleep Apnea
- ☐ Wake up Easily/Early
- ☐ Light Sleep
- ☐ Vivid Dreams/Nightmares
- ☐ Heavy Sleep
- ☐ Sound/Restful
- ☐ Difficulty Falling Asleep
- ☐ Dream Disturbed
- ☐ Other: _____

Hours of Sleep/Night: _____

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EMOTIONS:

☐ Poor Memory	☐ Impatient	☐ Manic
☐ Forgetful	☐ Over Thinking	☐ Stressed
☐ Anxious	☐ Irritability	☐ Anger/Frustration
☐ Depression	☐ Fearful	☐ Grief
☐ Sad	☐ Relaxed/Calm	☐ Joy/Happiness
☐ Cry Easily	☐ Other _____	

Are youPregnant? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No

Do you Use Birth Contro?l ☐ Yes ☐ No
If yes, what type of contraception do you use?: _____

Other concerns you would like to discuss with your TCM Doctor/Acupuncturist:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature: Date: dd/mm/yy

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PATIENT INFORMATION AND CONSENT FORM

Please read this information carefully, and inform your TCM Doctor/Acupuncturist if there is anything that you do not understand.

While acupuncture, Traditional Chinese Medicine, and other treatments provided for you by this clinic have proven to be highly effective in correcting conditions and maintaining overall health and well being, practitioners are required to advise patients of some possible risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, you and your practitioner will discuss these together during your consultation.

Possible side effects of acupuncture:

- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse. However, they will begin to improve for 1 - 2 days following the treatment. This is usually a good sign. Please inform your practitioner if your symptoms continue to worsen more than 2 days after the first treatment;
- Fainting can occur in certain patients.

Possible side effects of Traditional Chinese Medicinals and other treatments provided at this clinic:

- Formulas, herbs and supplements derived from plant, animal and mineral sources that have been prescribed are traditionally considered safe in the practice of Traditional Chinese Medicine. Although some may be toxic in large doses or inappropriate during pregnancy, so it is important to follow the directions prescribed by your practitioner.
- Bruising (like a circular hickey) is a common side effect of cupping.

It is important to remind your practitioner of any of the following:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a bleeding disorder;
- If you have damaged heart valves, or any other particular risk of infection;
- If you are taking anticoagulants (blood thinners) or any other medications;
- If you are pregnant;
- If you have a pacemaker or any other electrical implants;
- If you have ever experienced seizures;
- If you have high or low blood pressure.

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Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatment and procedures provided to me by this wellness center. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I am able to refuse treatment at any time. I wish to rely on my TCM Doctor/Acupuncturist to exercise fair judgment during the course of treatment which, based upon the facts then known, is in my best interest for optimum health care.

By signing below I show that I have read, and clearly understood, this consent to treatment. I am aware of the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition, and further conditions for which I seek treatment to achieve optimum well being.

Cancellation Policy

In signing this form, I also understand and accept that a fee of $50.00 (the full appointment fee) will be charged to my file if I cancel or reschedule within 24 hours prior to the date of my scheduled appointment.

Print name in full	(Print name of representative if represented by another)
Signature	(Signature of Representative)
Date dd/mm/yy	