Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Acupuncture Intake Form

Personal Information: Date: _____
First Name: _____ Last Name: _____
Address: _____
City/Province: _____ Postal Code: _____
Telephone: Home: _____ Cell: _____Work: _____
E-mail: _____ Alberta Health Care Number: _____
Date of Birth (DD/MM/YYYY): _____ Age: _____ Sex: _____
Occupation: _____
Please check what type of reminder you would prefer:
Email Reminder: ☐ Phone Call: ☐ Text: ☐ None: ☐
Emergency Contact Information: Name: _____ Phone: _____
How did you hear about Balanced Health and Sports Therapy? _____

Health Information:
Reason for consulting Balanced Health & Sports Therapy: _____
Have you ever had Acupuncture Care: ☐ Yes ☐ No When: _____
By whom: _____ for what condition: _____

List all surgical operations and years: _____

List all allergies: _____

List all family history of health problems:
_____
_____

List all the medication(s) you are currently taking (Include: Drug name, dose, frequency taken, for how long, reason):
_____
_____
_____

List all the vitamin(s) and or supplement(s) you are currently taking: (Include: Supplement name, dose, frequency taken, for how long, reason)
_____
_____
_____

PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

Please note our cancellation policy: If less than 24 hours' notice is given to cancel your appointment, your account will be charged the full price of the appointment.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.

_____ _____
SIGNATURE of Patient (or parent/guardian) **DATE**

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898

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Systems Review

Please Check / Answer Everything That Applies Below

General

- ☐ Catch cold easily
- ☐ Recurrent infections
- ☐ Night sweats
- ☐ Bleed or bruise easily
- ☐ Organ prolapse
- ☐ Strong thirst (hot or cold)
- ☐ Fatigue/low energy
- ☐ Sudden drops of energy
  - Time of day: _____
- ☐ Sudden change in weight

Skin and Hair

- ☐ Dry skin/scalp/hair
- ☐ Rashes/hives
- ☐ Itching
- ☐ Eczema
- ☐ Warts
- ☐ Acne
- ☐ Change in moles
- ☐ Hair loss/thinning hair

Sleep

- ☐ Difficulty falling asleep
- ☐ Wake up easily during the night
  - # Times per night: _____
  - What time: _____
- ☐ Wake up too early in the am
  - What time: _____
- ☐ Nightmares
- ☐ Vivid dreams
- ☐ Grinding teeth
- ☐ Talking in sleep
- ☐ Snoring

Circulation

- ☐ Cold hands or feet
- ☐ Swelling of hands/feet
- ☐ Blood clots
- ☐ Varicose veins
- ☐ Edema/swollen ankles
- ☐ Puffy eyes

Head, Ears, Eyes, Nose, Throat

- ☐ Headaches
  - Where: _____
  - When: _____
- ☐ Migraines
- ☐ Dizziness/vertigo
- ☐ Fainting spells
- ☐ Earache
- ☐ Change in hearing
- ☐ Ringing in the ears
- ☐ Blurry vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Spots before eyes
- ☐ Dry eyes
- ☐ Eye pain/sore eyes
- ☐ Excessive tearing
- ☐ Glasses/contacts
- ☐ Facial pain
- ☐ Facial paralysis
- ☐ Nosebleeds
- ☐ Blocked nose/sinuses
- ☐ Sinus infections
- ☐ Jaw pain
- ☐ Teeth/gum problems
- ☐ Recurrent sore throat
- ☐ Hoarseness/loss of voice
- ☐ Tonsillitis/swollen glands
- ☐ Sores on lips/mouth/gums
- ☐ Strange taste in mouth
- ☐ Swollen glands/lumps
- ☐ Oral ulcers
- ☐ Other: _____

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Nervous System

- ☐ Loss of taste/smell/touch
- ☐ Tingling sensations/numbness
- ☐ Tremors
  - Where: _____
- ☐ Lack of coordination/balance
- ☐ Paralysis or seizures
- ☐ Stroke
- ☐ Concussion
- ☐ Other: _____

Chest

- ☐ Pain in chest
- ☐ Tightness or pressure in chest
- ☐ Pain with breathing
- ☐ Difficulty breathing
- ☐ Shallow breathing
- ☐ Shortness of breath
- ☐ Recurrent/chronic cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Asthma/wheezing
- ☐ Production of phlegm
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart palpitations or rapid heartbeat
- ☐ Irregular heartbeat
- ☐ Other: _____

Muscles and Joints

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
  - Where: _____
- ☐ Hand/wrist pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Joint/bone problems
- ☐ Muscle pain/weakness
- ☐ Tremors/tics in muscles
- ☐ Osteoporosis
- ☐ Herniated disc
- ☐ Sciatica
- ☐ Other: _____

Digestion

- ☐ Little appetite
- ☐ Strong appetite
- ☐ Hunger but no desire to eat
- ☐ Food cravings
- ☐ Belching
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Regurgitation
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loose stools/diarrhea
- ☐ Dysentery
- ☐ Strong smelling stools
- ☐ Blood in stools
- ☐ Constipation (< 1 b.m./day)
  - Dry stools: ☐
  - Not daily: ☐
  - With difficulty: ☐
- ☐ Alternating constipation and diarrhea
- ☐ Gas/flatulence
- ☐ Hernia
- ☐ Rectal pain/prolapse
- ☐ Hemorrhoids
- ☐ Anorexia nervosa
- ☐ Bulimia
- ☐ Bad breath
- ☐ Other: _____

Mind and Emotions

- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Depression
- ☐ Often stressed
- ☐ Lose control of emotions
- ☐ Substance abuse
- ☐ Anxiety/nervousness
- ☐ Manic behavior
- ☐ Panic attacks
- ☐ Easily angered
- ☐ Aggressive behavior
- ☐ Other: _____

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Urinary

- ☐ Pain on urination
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Dribbling urination
- ☐ Urinary incontinence/retention
- ☐ Incontinence at night
- ☐ Do you wake to urinate?
  - How many times: _____
- ☐ Bladder/kidney infections
- ☐ Recurrent yeast infections
- ☐ Kidney stones

Male System

- ☐ Prostate problems
- ☐ Change in sexual drive
- ☐ Rashes/itching
- ☐ Genital discharge
- ☐ Erection difficulty
- ☐ Low sperm count/motility

Female System

- ☐ Premenstrual irritability
- ☐ Clots in menstrual blood
  - Color of blood: _____
- ☐ Irregular menses
- ☐ Painful menses
- ☐ Heavy/prolonged bleeding
- ☐ Missed menses
- ☐ Spotting/abnormal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Genital sores
- ☐ Ovarian cysts
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Breast lumps
- ☐ Breast swelling or redness
- ☐ Nipple discharge
- ☐ Abnormal Pap smear
- ☐ Infertility
- ☐ Other: _____

Are you pregnant now? ☐ Yes ☐ No

How many months: _____

Is it possible you're pregnant now? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Do you practice birth control? ☐ Yes ☐ No

What type and for how long: _____

Number of pregnancies: _____

Number of births: _____

Number of premature births: _____

Number of abortions: _____

Age of first menses: _____

Duration of menses: _____

First day of last menses: _____

Number of days in cycle: _____

Age of menopause: _____

Date of last pap smear: _____

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Chief Complaint(s)

_____

_____

_____

_____

_____

_____

_____

Lifestyle

Living Environment: ☐ Dry ☐ Damp

Favorite Food and Drink Type: ☐ Sour ☐ Sweet ☐ Salty ☐ Greasy ☐ Spicy

Do you drink? ☐ Coffee (__ # of Cups) ☐ Cold Drinks ☐ Warm Drinks

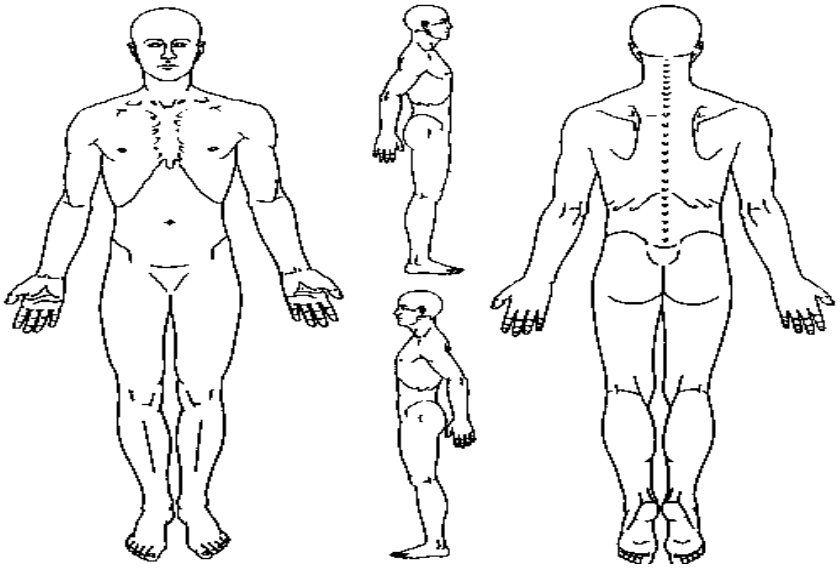
Do you use any of the following? ☐ Cigarettes ☐ Alcohol ☐ Recreation Drugs

What are your sources of stress? _____

Are you frequently in a state of: ☐ Fear ☐ Worry ☐ Anger ☐ Sadness ☐ Anxiety

Please comment on your level of exercise (Type & Frequency): _____

Please indicate on the diagram where you are experiencing pain:



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Patient Information and Consent Form

Please read this information carefully and ask your practitioner if there is anything that you do not understand. While acupuncture, Chinese Medicine and other treatments provided by 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. 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, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

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

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. 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 can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner 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. By voluntarily signing below I show that I have read this consent to treatment, have been told about 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.

Consent for Contact (Phone/Email/Text)

I consent to being contacted by Balanced Health and Sports Therapy via phone, email, or text for appointment reminders, scheduling, and relevant health information.

Signature

_____	_____	_____
Date Signed	Patient Name	Patient Signature (or Parent/Guardian)

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