General Patient Information

CONFIDENTIAL

To assist in providing you with the best possible care, please fill out this form as accurately as you can. All information will be kept confidential in your patient file.

Name: ____________________ Date: ____________

Date of birth: ____________________ Age: ____________

Address: ____

Phone number (cell): ____________________ (work): ____________

Email: ____________________ Occupation: ____________

Emergency contact: ____________________ Phone number: ____________

How did you hear about us? ____

Main Concerns

Please list the concerns that brought you here today

Health History

Please indicate any health conditions:

1 ____________________

When did this start? ____________________

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise/Activity: better no change worse

2 ____________________

When did this start? ____________________

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise/Activity better no change worse

3 ____________________

When did this start? ____________________

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise/Activity better no change worse

Please indicate any health conditions:

P past **C** current **F** family

Write **P** if you have had it in the past, write **C** if you currently have it, and write **F** if anyone in your immediate family had/has it.

____ Alcoholism	____ Hepatitis C
____ Allergies	____ High/low BP
____ Anorexia	____ High Cholesterol
____ Arthritis	____ HIV/AIDS
____ Asthma	____ Menstrual Disorder
____ Bulimia	____ Mental Illness
____ Cancer	____ Osteoporosis
____ Chemical Dependency	____ Pacemaker
____ Diabetes	____ Respiratory Disease
____ Depression	____ Skin Disease
____ Dizzy/Fainting	____ Stroke
____ Epilepsy	____ Thyroid Disease
____ Headaches	
____ Heart Disease	Other: ____________

Habits

	Amount/Day
Coffee/Tea	____________
Soda	____________
Alcohol	____________
Drugs	____________
Tobacco	____________

Please list any medications/supplements you are taking: ____________________

____

____

Exercise

Do you exercise regularly? ____________

What do you do and how often? ____________

____

Stress Level

Low Medium High

1 ________________________________ 10

General Health:

How is your energy level? ☐ low ☐ high

How is your body temperature ☐ cold ☐ warm

Do you sleep well at night? ____
How many hours/night? ________
☐ trouble falling asleep ☐ wake up at night
☐ wake up early ☐ don't feel rested

How many bowel movements/day? _______
☐ well formed ☐ loose
☐ hard ☐ alternate loose/hard
☐ dry ☐ long and thin
☐ rabbit pellets ☐ blood in stools
☐ mucous in stools ☐ feel unfinished
☐ early morning diarrhea

How many times do you urinate/day? _________
☐ clear ☐ cloudy
☐ yellow/dark yellow ☐ dark yellow
☐ painful ☐ urinate at night

How is your digestion?
☐ no appetite ☐ hungry
☐ gas ☐ belching
☐ heartburn ☐ bloating
☐ stomach pain ☐ abdominal pain

How is your thirst?
☐ thirsty ☐ no thirst
☐ thirst but no desire to drink ☐ like warm drinks
☐ like cold drinks ☐ like ice in drinks

Do you sweat?
☐ sweat easily ☐ don't sweat
☐ nightsweats ☐ day sweats

Which emotions do you experience on a daily basis?
☐ joy ☐ sadness/grief
☐ fear ☐ worry
☐ anxiety ☐ depression
☐ anger ☐ easily startled

Please check box if you experience any of the following symptoms regularly

☐headaches
☐migraines
☐pain in rib cage
☐frequent sighing
☐stress
☐moodiness
☐pain that comes and goes
☐pain that moves
☐grinding teeth
☐cold hands and feet

☐frequent colds
☐sinus congestion
☐sore throat
☐aversion to wind
☐aversion to cold
☐sneezing
☐runny nose
☐cough
☐shortness of breath
☐low immunity

☐ blurry vision
☐spots/floaters in front of eyes
☐eye dryness or pain
☐dizziness
☐poor memory
☐numbness
☐dry skin/hair
☐ligament/tendon problems
☐brittle fingernail/toenails
☐pale nails, lips, inner eyelids

❑hemorrhoids
❑crave sweets
❑bruise/bleed easily
❑varicose veins
❑overthink/analyze

❑bad breath
❑nausea
❑vomiting
❑indigestion
❑ulcers

❑ringing in ears
❑low back pain
❑knee pain
❑hot hands and feet
❑red cheeks in afternoon
❑dry mouth

❑muscle cramps
❑swollen joints
❑hot joints
❑sock marks on ankles
❑body pain

❑agitation/restlessness
❑palpitations
❑irregular heartbeat
❑chest pain
❑vivid dreams
❑nightmares
❑canker sores

❑change in sexual drive
❑erectile dysfunction
❑STD
❑prostate disease
❑hernia

# of pregnancies ______ #of births ______ #of premature births ______ #of abortions ______
Are you pregnant? ______ Are you trying to get pregnant? ______
Are you practising birth control? (what type, how long) ______
Do you still get your period? ______ If not, at what age did it cease? ______
How many days is your cycle? ______ How long does your period last? ______
What color is the blood? ______
What consistency is the blood? ______

❑irregular periods
❑infertility
❑breast lumps
❑vaginal discharge
❑endometriosis
❑late

❑painful
❑early
❑heavy
❑light
❑cramping
❑painful breasts

❑bloating
❑irritability
❑clotting
❑change in BM
❑fibroids

Poke Community Acupuncture

PATIENT INFORMATION AND CONSENT FORM

Please read the following carefully. We'd be happy to clarify anything that you do not understand.

- Acupuncture, herbs, and accompanying Chinese medicine therapies such as, moxibustion, cupping and guasha have been shown to be very effective in treating many conditions affecting the physical body and mental/emotional well-being. There are, however, some risks that may arise with these treatments. It is difficult as a practitioner to anticipate all the possible risks/complications that may arise with each individual but listed below are some of the more common ones:

Some potential side-effects:

- drowsiness may occur-please be aware that it may affect your ability to drive immediately after treatment
- minor bruising or bleeding may occur
- occasionally, symptoms get worse before they improve-this should only last a day or two. If they worsen for longer than 2 days please contact your practitioner.
- Chinese herbs may cause some digestive disturbance, skin rashes, and tingling of the tongue. Patients who experience discomfort or adverse reactions should stop taking the herbal formula and inform the practitioner.

- **It is important to let us know if any of the following conditions affect you:**
- Are you pregnant? Acupuncture can be very beneficial in the treatment of symptoms associated with pregnancy, as well as assisting in birthing preparation and post-partum. Please let us know if you are pregnant, or trying to get pregnant .
- Do you have a pacemaker or any other electrical implant?
- Do you have a bleeding disorder? Are you taking blood-thinners or any other medications?
- Do you have any medical condition that may increase your risk of an infection?
- Are you subject to fainting or feeling faint?

Privacy: Since several people are being treated in the same room at once it is vital that we work together to respect your privacy and the privacy of others. Information given is strictly private and confidential and is considered such by the practitioner. Let us know if there are certain topics that need extra discretion or if you prefer to do your intake in a more private setting. If you happen to overhear someone else's private information, please keep it to yourself.

Cancellation Policy: **Poke is dedicated to providing high quality, affordable, and compassionate acupuncture. If you miss an appointment with us, we miss your presence in the treatment room. It also means that someone else was not able to use that slot. Please give us 24 hours notice if you need to cancel your appointment. We ask for a donation to Poke from folks who miss appointments or who cancel on us with less than 24 hours notice.**

Returned Cheques: Please note there is a $5.00 charge for NSF cheques.

I have read and understood the above information and give my consent to treatment from the Registered Acupuncturists (R.Ac.) and Registered Traditional Chinese Medicine Practitioners (R.T.C.M.P.) who practice at Poke Community Acupuncture. I understand that consent for treatment may be withdrawn at any time.

____
Full name - please PRINT

____
Date

____
Signature