Healthquest Chiropractic & Natural Medicine Ltd.

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Acupuncturist and DTCM Intake Form Date: _____

Last Name: _____ First Name: _____ Gender: M / F

Address: _____ Postal Code: _____ Age: _____

Date of Birth (DD/MM/YY):_____ Alberta Health Number: _____

Primary Phone: _____ Secondary Phone:_____ email: _____

Occupation: _____ Marital Status: _____ Children: _____

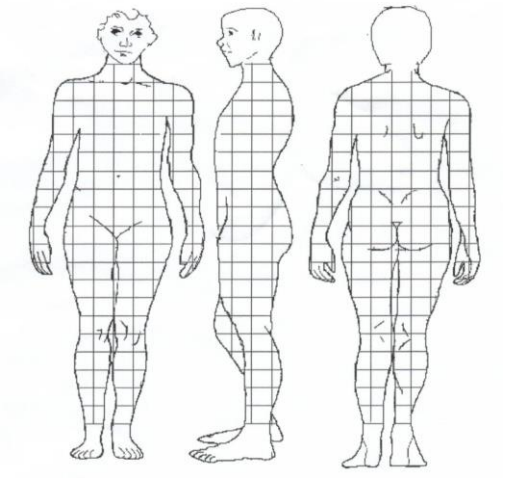
Emergency Contact: _____ Phone: _____ Relationship: _____

Family Physician: _____ Clinic's Name: _____ Phone: _____

Drug Allergy (reaction eg. rash): _____

Chief Complaints (how long): 1. _____ 2. _____ 3. _____

PAIN ☐ yes ☐ no, if yes, Please indicate on the diagram where you are experiencing it:
Pain scale before treatment: nothing 0 <- 1 2 3 4 5 6 7 8 9 10 -> Most severe
Pain scale after treatment: nothing 0 <- 1 2 3 4 5 6 7 8 9 10 -> Most severe (doctor)



When did this start?

_____

When happened?

_____

When makes it better?
☐ Heat ☐ Cold
☐ Pressure like massage
☐ Mild movement, exercise
☐ Others: _____

What makes it worse:
☐ Heat ☐ Cold ☐ Stress
☐ Pressure like massage
☐ Mild movement, exercise
☐ Others: _____

Family Medical History:

Relationship	Present &/or Past Health Problems	Note

Current Medication(s) and Supplement(s)

Name of Medication	Dose (mg/g/ml/unit)	Frequency	Name of Medication	Dose (mg/g/ml/unit)	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Personal Medical History

(Name) (Date of Birth) (Age) (Today's Date)

Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

Genitourinary
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

Eye, Ear, Nose and Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

Skin
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Women only
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____
How many children do you have? _____

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

LIFESTYLE

Living Environment: ☐ Dry ☐ Damp; Basement living: ☐ yes ☐ no , if yes, for how long _____

Craving for /Favourite food and drink: ☐ SWEET ☐ SALTY ☐ SPICY ☐ FRIED ☐ SOUR

Beverage: ☐ Coffee, cup(s)/ day; ☐ Alcohol, specify: _____, glass(es)/bottle(s) per week

How many glasses of WATER per day: _____

Smoking: ☐ yes ☐ no, if yes, what type: _____ Recreational Drug: ☐ yes ☐ no, if yes, what type:_____

Mental State of Mind: ☐ Fear ☐ Worry ☐ Anger ☐ Sadness ☐ Anxiety

Main Source of Stress: ☐ Work ☐ Spouse ☐ Children ☐ Parents ☐ Friends ☐ Relationship ☐ Other_____

Exercise (type): _____ frequency: _____ ☐ none ☐ light ☐ moderate ☐ heavy

DIET: ☐ regular ☐ irregular ☐ skip meal(s) ☐ food partiality

Food Allergy: ☐ yes ☐ no, if yes, what type: _____When did it start: _____

SYMPTOMS AND EVALUATION

*BP: _____ mmHg (to be filled by practitioner) Heat Rate: _____ beats/minute

ENERGY Level: lowest 0 <- 1 2 3 4 5 6 7 8 9 10 -> Highest, note: _____

STRESS Level: lowest 0 <- 1 2 3 4 5 6 7 8 9 10 -> Highest, note: _____

SLEEP:☐ Insomnia ☐ Somnolence ☐ Difficulty falling asleep ☐ Wake up *in the middle of night, what time:*_____
☐ cannot fall back asleep ☐ Dream disturbance ☐ Vivid dream/ remembering ☐ not restful in the morning

FEVER & CHILLS: ☐ Fever ☐ Alternating fever & chill ☐ Aversion to Heat ☐ Chills or Aversion to Cold

HEADACHE: ☐ Distending ☐ Heavy ☐ Pricking ☐ Burning; ☐ Top of head ☐ Forehead ☐ Occipital ☐ Temporal

SWEATING: ☐ Night sweating ☐ Spontaneous ☐ Light ☐ No ☐ Heavy with high fever ☐ Heavy with Cold limbs

DIZZINESS: ☐ yes ☐ no, if yes, any specific time:_____

COUGH: ☐ Dry ☐ Scanty Phlegm ☐ Profuse Phlegm ☐ Yellow ☐ White ☐ Wheezing ☐ Asthma ☐ SOB

EYE: ☐ Blurred vision ☐ Eye Pain ☐ Red/Itching Eyes ☐ Dry Eyes ☐ Photophobia ☐ Abnormal Eye Discharge

EAR: ☐ Decrease or loss of hearing ☐ Tinnitus ☐ High pitch ☐ Low pitch ☐ Ear Pain ☐ abnormal ear discharge

FACE: ☐ Jaw Pain ☐ Gum Bleeding ☐ Loose Teeth ☐ TMJ ☐ Other: _____

APPETITE: ☐ Normal ☐ Under eating ☐ Over eating ☐ Easily Hungry ☐ Hungry but no desire to eat

THIRST: ☐ thirsty & drink lots ☐ thirsty but NO desire to drink ☐ Prefer Room temp./WARM drinks ☐ Prefer COLD

Taste in Mouth: ☐ Bitter taste ☐ in the morning ☐ sour ☐ drooling saliva

CHEST Pain or Discomfort: ☐ Burning ☐ Pricking ☐ Dull ☐ Chest Fullness ☐ Chest Tightness ☐ Distending

PALPITATON: ☐ yes ☐ no ☐ Regular ☐ Irregular

GI: ☐ Nausea ☐ Vomiting ☐ Belching ☐ Hiccup ☐ Indigestion ☐ Flatulence ☐ Esophageal Reflux

GASTRIC PAIN: ☐ Burning ☐ Distending ☐ Pricking ☐ Dull ☐ only happen or worse after eating

HYPOCHONDRIAC PAIN: ☐ Burning ☐ Distending ☐ Pricking ☐ Dull ☐ Occasionally _____

ABDOMINAL PAIN: Cramping Distending Pricking Dull

Above PAIN Relieved with: ☐ Cold ☐ Heat ☐ Pressure ☐ after eating

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BOWEL movement (BM): _____ time(s) per day ☐ Formed ☐ Loose ☐ Dry ☐ moist ☐ black stool

Constipation: ☐ yes _____ time(s) of BM/ week ☐ Formed ☐ Dry ☐ incomplete emptying
☐ feel better after BM ☐ feel worse after BM

Diarrhea: ☐ yes ☐ Watery ☐ Loose ☐ Undigested food ☐ abdominal pain ☐ Smelly ☐ sticky
☐ better after BM ☐ worse after BM
☐ at dawn, 5 am ☐ morning, 7-11 am

URINATION: ☐ Clear ☐ Light Yellow ☐ Dark Yellow ☐ Turbid ☐ Low volume ☐ High volume ☐ Dribbling
☐ Frequent all day ☐ Frequent at night ☐ Dysuria ☐ Incontinence ☐ Urinary Retention ☐ Enuresis

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MENSTRUATION: Cycle: _____ day per cycle; Number of bleeding days: _____ Number of heavy days:_____
☐ Regular ☐ Early ☐ Delay ☐ Light Red ☐ Dark Red ☐ Bright Red ☐ Thin ☐ Thick
☐ Clots, Size of clots_____ ☐ Abdominal Pain
☐ Amenorrhea, when _____ ☐ Menopause, when: _____ Date of last Period:_____

LEUKORRHEA: ☐ Yellow discharge ☐ White Discharge ☐ Thin discharge ☐ Thick discharge
☐ Smelly discharge ☐ Large Amounts

PREGNANCY & DELIVERY: ___ Children ___ Miscarriage ___ Abortion(s) ___ Vaginal Delivery ___ Difficult Delivery

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SEXUAL ENERGY: ☐ Increased ☐ Decreased ☐ No Sexual Drive ☐ Infertility

MALE: ☐ Impotence ☐ Premature Ejaculation ☐ Sperm

CHILDREN: Process of Birth: ☐ Vaginal Delivery ☐ C-section ☐ Other, _____

Possible related causes: ☐ Cold ☐ Fear or Threat ☐ Improper Food, specify: _____

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Acupuncturist and DTCM Consent Form

According to the Alberta Acupuncture Legislation, an acupuncturist must not treat someone who has not consulted with a physician or other health specialist(s) about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable box confirming that:

- ❑ I have already seen a physician or other health specialist(s) regarding the condition(s) that I am seeking care and treatment from the acupuncturist & DTCM of the Healthquest Chiropractic & Natural Medicine Ltd
- ❑ I agree to see a physician or other health specialist(s) regarding the condition(s) that I am seeking care and treatment from the acupuncturist & DTCM of the Healthquest Chiropractic & Natural Medicine Ltd.

Patient Consent Form for Acupuncture

Traditional Chinese Medicine (TCM) and Acupuncture is a holistic therapy with thousands of years of history and have numerous studies and evidence about its safety and efficacy. I understand that there is no guarantee or warranty for a specific cure or result. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is our practice to inform our patients about them. These complications may include, but not limited to, pain, fainting, bruises, swelling, post-acupuncture sensation (numbness, tingling, heaviness, and tiredness), and temporary exacerbation of symptoms, infection at site of needle insertion, allergic reactions to supplements or herbs, and inconvenience of lifestyle changes.
More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.
I also understand that there are precautions and contraindications for some of my treatments. It is my responsibility to inform the acupuncturist if any the following applies to me:
famished, over-eaten, intoxicated, over-fatigued or very weak, pregnant.

I have read and fully understand the above statement, accept the risk, and thereby consent to treatment. I accept full responsibility for any fees incurred during care and treatment.

_____ Date: _____
Patient's Name (Please Print)

_____ Date: _____
Signature of patient or legal guardian: _____

_____ Date: _____
Signature of Acupuncturist & DTCM

Cancellation Policy:
All appointments must be cancelled **24 hours in advance**. If sufficient notice is not given to the clinic**, a fee equal to the cost of the visit will be levied.**
Refund policy:
Just as with any prescription that is prescribed for you by a physician, there is **no refund for any reason** on any herbal prescriptions that are specifically made for you.