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: _____

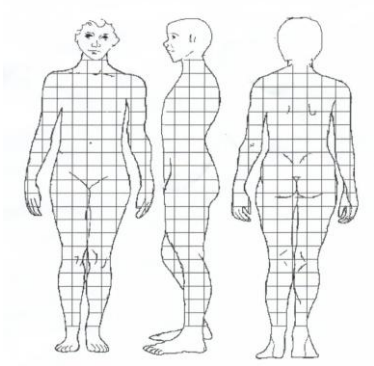
Family Physician: _____ Clinic's Name: _____Phone: _____

Drug Allergy (& reaction eg. rash): _____

Chief Complaints (for how long):

1. _____ *(for how long)*
2. _____ *(for how long)*
3. _____ *(for how long)*

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 (for 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:		
Personal Medical History		
Current Medication(s)		

LIFESTYLE

Living Environment: ☐ Dry ☐ Damp ☐ Basement living, 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:_____
State of Mind: ☐ Fear ☐ Worry ☐ Anger ☐ Sadness ☐ Anxiety
Main Source of Stress: ☐ Work ☐ Spouse ☐ Family ☐ 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 (can 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 often, __ *time(s), at* _____ ☐ Wake up Early
☐ cannot fall back asleep ☐ Dream disturbance ☐ Vivid dream/ remember ☐ 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 ☐ Overeating ☐ Easily Hungry ☐ Hungry but no desire to eat
THIRST: ☐Thirsty & drink lots ☐Thirsty but NO desire to drink/Sip ☐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 ☐ Family history with heart condition
GI: ☐ Nausea ☐ Vomiting ☐ Belching ☐ Hiccup ☐ Indigestion ☐ Flatulence ☐ Esophageal Reflux
GASTRIC PAIN: ☐ Burning ☐ Distending ☐ Pricking ☐ Dull ☐ 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 ☐ After Period

---

BOWEL movement (BM): ___ time(s) per day ☐ Formed ☐ Loose ☐ Dry ☐ moist ☐ black stool ☐ Rabbit poop
Constipation: ☐ Yes ___ time(s) of BM/Week ☐ Formed ☐ Dry ☐ Incomplete emptying ☐ Burning sensation
☐ feel Better after BM ☐ feel Worse after BM ☐ Tired after BM
Diarrhea: ☐ Yes ☐ Watery ☐ Loose ☐ Undigested food ☐ Abdominal pain ☐ Smelly ☐ Sticky ☐ Burning
☐ 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 ☐ more at Night ☐ Dysuria (Pain) ☐ Incontinence ☐ Urinary Retention ☐ Enuresis

---

MENSTRUATION: Cycle: _____ days per cycle; Number of Bleeding days: _____ Number of Heavy days:_____
☐ Regular ☐ Early ☐ Delay ☐ Light Red ☐ Dark Red ☐ Bright Red ☐ Brown ☐ Thin ☐ Thick
☐ Clots Size of Clots: ☐ Fist ☐ Loonie ☐ Quarter ☐ Nickel ☐ Dime ☐ Grain of Rice ☐ Abdominal Pain

☐ Amenorrhea, when _____ ☐ Menopause, when: _____ Last Period _____*Date*___

VAGINAL DISCHARGE: ☐ Yellow ☐ White ☐ Thin ☐ Thick ☐ Smelly ☐ Large volume

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

---

SEXUAL ENERGY: ☐ Increased ☐ Decreased ☐ No Sexual Drive ☐ Infertility
MALE: ☐ Impotence ☐ Premature Ejaculation ☐ Spermatorrhea

CHILDREN: Process of Birth: ☐ Vaginal Delivery ☐ C-section ☐ Difficult Delivery ☐ Other, _____
Possible related causes: ☐ Cold ☐ Fear or Threat ☐ Improper Food, specify: _____

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
- ❑ 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

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.