Acupuncture/Traditional Chinese Medicine Intake Form

Please complete all the fields below as accurately as possible, even if you feel certain questions don't pertain to your current condition. All information is kept confidential. Thank You.

Name: _____ Date: _____
Address: _____
City_____ Province_____ Postal Code_____
Email: _____
Phone: (C) _____ (H) _____ (W) _____
Height: _____ Weight: _____ Sex: _____
Date of Birth: _____ Age: _____
Occupation: _____
Primary Physician: _____ Phone Number: _____
Referred by: _____
Emergency Contact: _____Phone: _____

Main problem/s you would like help with:
1.
2.
3.
When did the problem/s begin (be specific):

To what extent does the problem/s interfere with your daily activity (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem/s? If so, then what?

What kind of treatments have you tried? Other concurrent therapies:

Medications:

Do you have a regular exercise program? Please describe.

Please indicate usage per day or per week:

Water _____ glasses per day
Coffee _____ cups per day/week (circle)
Tea _____ cups per day/week (circle)
Alcohol _____ day/week Type liquor/beer/wine (circle)
Soft Drinks _____ day/week (circle)
Cigarettes _____ day/week (circle)
Sweets _____ day/week (circle)

HEAD/NECK

- □ Headache
- □ Migraine
- □ Visual Disturbances
- □ Contact lenses/glasses
- □ Earaches
- □ Hearing Problems
- □ Jaw Pain/Dental Problems

CARDIOVASCULAR

- □ High blood pressure
- □ Low blood pressure
- □ CCHF
- □ Poor circulation
- □ Heart Disease
- □ Stroke
- □ Pacemaker
- □ Heart attack

RESPIRATORY

- □ Asthma
- □ Chronic cough
- □ Shortness of breath
- □ Bronchitis
- □ Emphysema
- □ Smoker

DIGESTIVE/URINARY

- □ Difficult Digestion
- □ Constipation
- □ Liver/Gallbladder
- □ Kidney/Urinary
- □ Diabetes
- □ Hypoglycemia
- □ Crohn`s Disease
- □ IBS

SKIN

- □ Bruise easily
- □ Eczema
- □ Psoriasis
- □ Varicose Veins
- □ Loss of sensation (Please specify)_____

INFECTIOUS CONDITIONS

- □ Tuberculosis
- □ HIV
- □ Hepatitis Type: _____
- □ Infectious skin conditions:_____

MUSCLE/JOINTS

- □ Neck
- □ Low back
- □ Mid back
- □ Upper back
- □ Shoulder
- □ Hip
- □ Knee
- □ Ankle

FEMALE

- □ Menstrual problems
- □ Pregnancy *Due Date:* _____
- □ Menopausal problems
- □ Gynaecological

OTHER

- □ Hemophiliac
- □ Epilepsy
- □ Cancer
- □ Location:_____
- □ Arthritis OA___ RA___
- □ Fibromyalgia
- □ Osteoporosis
- □ Chronic Fatigue Syndrome
- □ Scoliosis
- □ Carpal tunnel syndrome
- □ Fainting/dizziness/loss of consciousness
- □ Hernia

Informed Consent to Acupuncture Traditional Chinese Medicine

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Tanya Hilliard (D.Ac., R.Ac.)

- Acupuncture and other Traditional Chinese Medical procedures including diagnostic techniques such as questioning, pulse evaluation, tongue evaluation, abdominal evaluation, observation, range of motion, muscle or orthopedic testing
- Manual or physical therapy including cupping, direct moxabustion, electrical stimulation, infrared heat therapy
- Dietary recommendations
- Exercise advice and healthy lifestyle counselling.

I have had an opportunity to discuss with Tanya Hilliard (D.Ac., R.Ac.) and/or other clinic personnel the nature and purpose of Acupuncture and Traditional Chinese Medicine. Although I am aware that Acupuncture and the other Traditional Chinese Medicine procedures have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Traditional Chinese Medicine there are some risks to treatment. I understand that although these risks are highly unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, burns, pain or other strong sensation at the location of needle insertion or radiating from that location, nerve pain, aggravation of current symptoms (healing crisis), appearance of new symptoms, or general aches and pains. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist's judgment during the course of my treatment.

I have read (or had read to me) this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Tanya Hilliard (D.Ac., R.Ac.).

This is to confirm & acknowledge that the above mentioned information is correct and accurate to my knowledge and that I give consent for my treatment by a Registered Massage Therapist. I also acknowledge the policy that appointments missed or cancelled with less than 24 hour notice will be subject to a $25.00 charge.

Signature: _____ Date: _____