Harmony Health
INTEGRATIVE CENTRE

ADULT INTAKE FORM

Our health is influenced by many different factors. Your health history provides valuable information to help me understand your current health. Please fill out this form to the best of your ability and bring it with you to your first visit.

GENERAL CONTACT INFORMATION

Name _____ Today's Date: _____
(*Last name*) (*First name*)

Birthdate: _____ Age: _____ Gender: _____

Address: _____
Street *City* *Province* *Postal Code*

Phone: _____ E-mail: _____

Occupation: _____ How did you hear about the clinic? _____

Medical Doctor: _____ Last Physical Exam: _____
Name *Telephone* *(M/Y)*

Emergency Contact: _____
Name *Phone Number* *Relationship*

If you are completing this form for another person, what is your relationship to that person?_____

Do you have health benefits that cover Acupuncture? Yes No Provider:_____

CHINESE MEDICAL INTAKE

Have you had acupuncture before? Yes No

Reason for Acupuncture visit Today?_____

_____

Have you seen a medical Doctor for this condition? Yes No

Where is your pain: _____

_____

On a scale from 1-10 (with 10 being the worst), what would you rate your pain today? _____

Circle what makes your pain better or worse?

Cold/ Icepack	At rest	Stress	In the evening
Heat	Being active	Waking up	Other
Pressure	Being tired	During the night	

Please explain _____

Please circle any of the following conditions or symptoms you have had in the last 6 months:

Head:

Dull feeling/ Thinking	Migraines	Tight band around head	Cold Sores
Dizzy	Frequent headaches	Decline of memory	Facial palsy/ tics
Vertigo	Pain	Canker sores	Bleeding gums

Location of Headaches:

Unilateral	Behind eye(s)	Forehead	Fixed
Bilateral	Occipital/neck	Whole head	Moving
Temples	Top of the head	Sinuses	

What type of pain do the headaches present with?

Boring	Achy	Full	Bursting
Stabbing	Throbbing	Stiffness	Empty
Dull	Wrapped up	Pulling	

What makes it better? _____ What triggers/ aggravates it? _____

Eyes:

Red	Discharge	Dry	Light sensitivity
Painful	Blurred vision	Weak vision	Cataracts
Itchy	Floaters or Spots	Feeling of pressure	Glaucoma
Watery	Puffy	Needle-like pain	

Ears:

Ringing	High pitch/Low pitch	Deafness	Pain

Nose:

Dry	Allergies	Sneeze often	Catch cold easily
Thick/Sticky mucous	Runny/ Thin mucous	Shortness of breath	Nosebleeds

Throat:

Sore throat	Dry throat	Parched with no thirst	Difficulty swallowing
Chronic cough	Clear throat often	Lump in throat	Dry mouth
Phlegm	Parched with thirst	Wheezing	Excess mucous

Body /Limbs:

Weak	Tingling	Feeling of heaviness	Sore knees
Numbness	Stabbing pain	Sore back	

Skin:

Pale complexion	Wrinkling	Puffy	Itchy/Prickling
Pasty	Saggy	Edema (water retention)	Bruise easily
Redness of the face	Dry	Itchy	Bleed easily
Darkness	Thin	Eczema	

Muscles:

Weak	Stiffness	Spasms	Swollen
Cramping	Tension	Atrophy	Trembling
Flaccid	Twitching	Sore	Tenderness

Temperature/ Sweat:

Perspires easily	Feeling hot in afternoon	Clammy hands/ feet	Prefer hot food
Night sweats	Feeling heat in stomach/	Easily chilled	Prefer hot drinks
Hot Flashes	chest	Prefer cold food	Chills
Flushed/Hot face	Cold limbs	Prefer cold drinks	Fever
Hot limbs	Cold hands only	Spontaneous Sweating	Alternating chills & fever
Feeling of heat in body	Cold in hands and feet	Night Sweating	

Fluid Metabolism:

How much liquid to you consume daily? _____ Are you thirsty? Yes No

What temperature of beverages do you prefer? Hot Cold Room temperature

Urination:

Frequent	Weak Urine Stream	Dark yellow	Kidney Stones
Profuse (large amount)	Trouble Starting	Urine with bubbles	Urinary Tract Infection
Scanty (small amount)	Difficulty urinating	Urine with odor	Cloudy Blood in the Urine
Urgency	Clear	Incontinence	

Bowels/Gastrointestinal:

Frequency of bowel movements: _____ x per day/week

Constipation	Hemorrhoids	Foul/strong odor	Metallic taste
Dry/hard stool	Bleeding	Difficult movements	Sticky taste
Diarrhea	Gas pains	Slow digestion	Loss of appetite
Difficult to Pass	Sharp pain	Undigested Food	Gnawing hunger
Sticky	Feeling of fullness	Pellet-like Stools	Belching
Small, round bits	Bloating	Mucous in Stool	Nausea
Soft stool	Cramping	Blood in Stool	Vomiting
Loose stool	Burning	Bitter taste	Heartburn

Indigestion	Ulcers	Diarrhea & Constipation	
Vomiting blood	Acid reflux	Food cravings: _____	

Sleep:

How many hours/night: _____	Waking to Urinate? # of times: _____	Specific time? _____	Do you wake up rested? Yes No
Restless	Trouble falling asleep	Insomnia	Fatigue in the morning
Wake up often	Trouble staying asleep	Erratic Sleep	

Energy:

High energy	Lethargic	Tired in the afternoon	Tired
Excitable	Exhausted	Restless	

Weight:

Easy to lose weight	Easy to gain weight	Progressive weight loss	Feeling of heaviness

Emotions:

Anxiety	Chest Tightness	Talkative	Fearful
Depression	Easy tears	Laughs often	Easily startled
Worry	Irritable	Panic Attacks	Racing Thoughts
Sadness	Easily angered	Overthinking	Jealousy
Grief	Resentful	Think about the past often	Difficult to let things go
Poor Memory	Joyful	Frequent Sighing	Worry

Stress:

How would you rate your stress level? (1 low – 10 high): _____
How does your stress manifest itself?_____
How do you cope with your stress? _____

Male Reproductive:

Vasectomy	Painful erection	Erectile difficulty	Testicular lumps
Prostate problems	Difficult ejaculation	Penile discharge	Pain in testes
Male infertility	Premature ejaculation	Swelling in testes	Last prostate exam: ____

Female Reproductive:

Age of first period? _____		Date of Last Period: _____	
Periods occur every_____ days and last _____ days		Number of pregnancies?_____	
Are your periods regular? Yes No		Number of Children? Their ages? _____	
Heavy flow	Spotting	Dark red flow	Watery flow
Light flow	Clots	Brown/black flow	Heavy Flow
Even flow	Bright red flow	Pale red	No Flow

PMS/Menstruation:

Mood changes	Dizziness/faint	Infertility	Unpleasant odor
Irritability/anger	Abdominal bloating	Painful periods	Genital eruptions
Anxiety	Increased appetite	Lumps in breast	Painful sex
Insomnia	Sweet cravings	Nipple discharge	Lack of sexual desire
Crying	Weight gain	Breast pain	Excessive sexual desire
Forgetfulness	Breast tenderness	Pelvic pain	
Clumsiness	Back pain	Vaginal discharge	
Fatigue	Cramping	Vaginal itching/burning	

PREVIOUS MEDICAL HISTORY

Please indicate any health diagnosis, illnesses, injuries, surgeries and hospitalizations along with approximate dates:

_____

_____

_____

Do you have any dietary restrictions? (Religious, Vegetarian, Vegan, etc.)? _____

Do you have any allergies or hypersensitivities to any of the following?
Foods: _____
Medicines: _____
Environment: _____
Other: _____

Please list all prescription, over the counter medications, herbs, vitamins or supplements you are currently taking:
_____

_____

_____

Do you Smoke? Yes No

Do you Drink Coffee? Yes No If so, how many cups per day? _____

Do you exercise? What Kind, how often? _____

What is your diet like?
_____

_____

FAMILY MEDICAL HISTORY

Do you have any blood borne or infectious disease? YES NO

FAMILY MEDICAL HISTORY: Please state if you or an immediate family member has experienced any of the following:

Condition	Family Member	Condition	Family Member	Condition	Family Member
Allergies/ Hay Fever		Glaucoma		Mental Illness	
Alcoholism/ Drug Addictions		Headaches		Multiple Sclerosis	
Alzheimer's / Parkinson's		Heart Disease		Myasthenia gravis	
Anemia		Hepatitis		Osteoporosis	
Arthritis		High Blood Pressure		Obesity	
Asthma		High Cholesterol		Seizures	
Autoimmune Disease		HIV/AIDS		Skin Conditions	
Cancer		Kidney Disease		Stroke	
Celiac Disease		Liver Disease		Syphilis	
Diabetes		Low Blood Pressure		Thyroid Conditions	
Digestiion (Crohn's, Colitis, etc)		Lung Disease		Tuberculosis	
Epilepsy		Lupus		Other	
Fibromyalgia		Menstrual Issues			

Thank you for completing this form. The info provided will be discussed in further detail during your initial visit.

ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE DISCLOSURE STATEMENT & INFORMED CONSENT

I Hereby request and consent to the performance of acupuncture procedures and any form of Traditional Chinese Medicine treatments (Cupping, Gua Sha, Moxabustion, Tui Na, Auricular Therapy/Ear Seeds) for my stated health concern by Naomi Wegleitner, RAc., DTCM. I have been informed that acupuncture is a safe method of treatment. Some discomfort may be experienced. This may include, but not limited to, side effects such as discomfort, pain, dizziness, bruising, or numbness. Unusual and rare risks of acupuncture include nerve damage, organ puncture, infection, premature birth, or miscarriage. Other side effects and risks may also occur

If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I authorize this consent form to cover the duration of my treatments.

I understand that there are no guarantees regarding cure or improvement of my condition. I have discussed the nature and purpose of my treatment with my practitioner. I understand that there may be limitations to the care and treatment provided and that in my best interest I may be referred to another acupuncture practitioner or other health care provider who may be more qualified to treat me outside these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and permit the acupuncturist to determine and / or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time. I understand that I also have the choice to stop, change or modify my treatment plan. I have communicated any known or risk of blood borne infectious diseases I might be carrying.

PRIVACY: All information discussed is strictly confidential, in accordance with the confidentiality of information under the Health Disciplines Act from the Canadian Association of Acupuncturists of Alberta.

I am aware of fees posted at Harmony Health Integrative Centre with Naomi Wegleitner RAc, DTCM.

I have read or had read to me the above consent. I have also had the opportunity to ask and clarify any questions about its content and may withdraw treatment at any time. By signing below I agree to all terms and conditions stipulated by this document. I intend and am aware this form to cover the entire course of treatment for my condition and for any further condition(s) for which I am treated for.

_____ _____

Patient/Guardian signature/Authorized Representative Date

_____ _____

Signature of Practitioner Date

Cancellation and Direct Billing Policy only need to be completed ONCE for the entire Clinic

CANCELLATION POLICY

If I am unable to make a scheduled appointment I must provide 24 hours advance notice to avoid being charged a missed appointment fee that can be either $50 or the full cost of the visit. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements, cost of laboratory tests, administrative fees as well as any other applicable fees.

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a “no-show”. They will be charged for their “missed” appointment and all future services will be denied until the account is settled.

In the event that an appointment is cancelled or rescheduled with less than 24 hours’ notice you are subject to a late cancellation fee of $50.

Patient(s) Name:_____

Signature of Patient or Guardian: _____ Date: _____

DIRECT BILLING AND CREDIT CARD POLICY

Direct Billing with insurance provides a preauthorization for payment. However, in some cases the amount authorized can change when payment is received or the payment may be sent to the plan member instead. Therefore, it is clinic policy in order to direct bill any insurance company that a valid credit card must be provided and kept on file. The credit card information provided below will only be used in the event that less than 24 hours’ notice was provided for cancellations or changes, no show appointments, supplement refills or if insurance does not pay Harmony Health Integrative Centre the amount authorized. In the event the credit card does not work, the balance owing must be paid within 5 business days of being advised. Harmony Health Integrative Centre reserves the right to cancel any future appointments until this is done. The credit card must be updated in order to direct bill in the future as well.

Patient’s Name: _____

Credit Card information: Visa MasterCard

Name on Card (please print): _____

Credit Card Number: _____

Expiration Date (Month/ Year): _____ CVV:_____

Cardholder’s Full signature: _____ Today’s Date: _____