ACUPUNCTURE ON EGLINTON
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NEW PATIENT INTAKE FORM

			Today's Date:
Name:		Sex: ☐ F ☐ M	Date of Birth:
Address: Street	City	Province	Postal code
Home phone:	Work phone:	Cell phone:	
E-mail address:	Emergency contact: Name/Number & Relationship		
Marital status: ☐ single ☐ married ☐ divorced ☐ widowed			
Occupation:	Height:	Weight:	Age:
Physician name/ phone #:			
Who referred you?			

Please answer the following questions to the best of your ability.

What is the reason(s) for your visit? Ex. Low back pain, sinus congestion, infertility, etc.

_____

_____

_____

_____

Describe the history of your condition(s). When it began, the progression, previous treatments.

_____

_____

_____

_____

_____

_____

Write next to the conditions that apply "current" if experienced in the last 30 days or "past" if you have a prior history of the condition. In empty space please write any condition(s) not listed.

Anemia:	Diabetes:	Osteoporosis:
Anxiety	Frequent headaches:	Skin condition:
Arthritis:	Gallstones:	Thyroid condition:
Asthma:	High blood pressure:	Ulcer:
Cancer:	HIV/AIDS:	Urinary tract infection:
Chest pains:	Heart condition:	Weight change:
Chronic cold/flu:	Kidney condition ie. stones, nephritis:	
Chronic fatigue:	Liver problems i.e. fatty liver, cirrhosis, hepatitis:	
Depression:	Mononucleosis:	

List any surgeries and medical procedures you have had in the past or are scheduled to have in the future.

_____
_____
_____

List all medications and supplements taken within the last 60 days. Provide list if necessary.

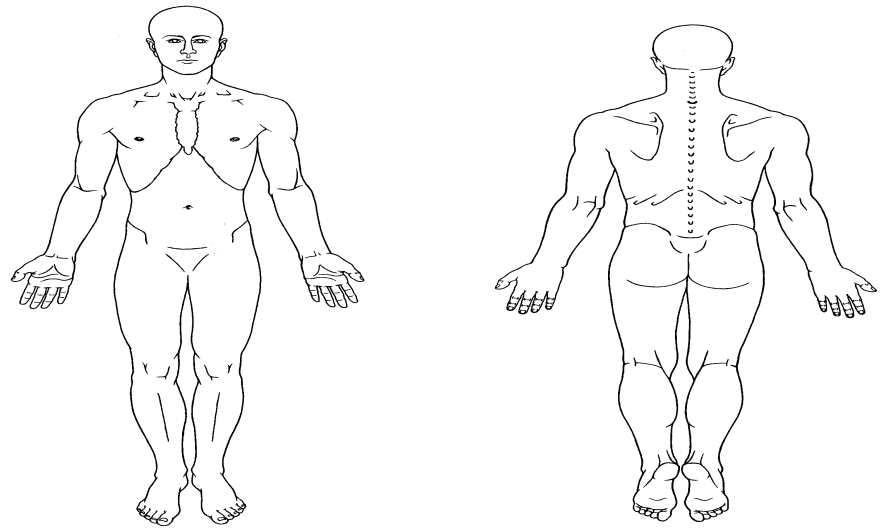
_____
_____
_____
_____

1) PAIN

Are you currently experiencing pain? Please describe.

_____
_____
_____

Mark the diagram below with an "X" for pain and "O" for numbness. Use arrows ↑ ↓ to demonstrate the flow of pain or numbness.



2) DIGESTION

Describe your average daily diet? Breakfast, lunch, and dinner. Snacks? Do you eat at regular times throughout the day?

_____
_____
_____
_____

Are you aware of any food allergies or sensitivities?

_____
_____

Describe your bowel movements. Are they formed, loose, hard, painful? Odor? How frequent?

_____

_____

Describe your urination. Frequency? Do you experience any pain or urgency when you void? What is the color? Ex. clear or cloudy, dark yellow, light yellow?

_____

_____

Do you experience gas or bloating? When?

_____

3) ENERGY & WORK/REST

Describe your energy level. Do you have enough energy to get through the day? Are you easily fatigued?

_____

Do you exercise? If so, please describe your routine?

_____

How is your sleep? How many hours do you get a night? When do you go to bed? Do you fall asleep easily? Do you wake throughout the night? Do you experience vivid dreams? What time do you wake up? Do you feel rested when you wake?

_____

_____

4) UPPER RESPIRATORY

Do you have difficulty breathing or shortness of breath? If yes, describe when this occurs.

_____

Do you have any allergies (other than food)?

_____

Do you experience frequent sinus congestion? Is there pain or infection associated with your congestion? Sinusitis, or migraine headache? When does this occur?

_____

5) EMOTIONS

How are you feeling today?

_____

Describe your overall emotional state for the past 30 days. Are you typically happy and optimistic? Do you often feel overwhelmed and frustrated?

_____

6) MALE

Do you have any history of prostate problems such as an enlarged prostate? If so, describe.

_____

Do you feel that your libido is too high or too low?

_____

Describe any problems or concerns you may have regarding sexual function. Ex. pain during sex.

_____

7) FEMALE

When was the first day of your last menstrual period?

_____

How many days are in your cycle? Ex. combined menstrual days and non menstrual days ie. 28 days?

_____

Describe your menstrual period. How many days? Heavy or light flow? Color of blood? Clots? Cramps? Breast tenderness or swelling? Irritability?

_____

_____

_____

When was the date of your last PAP smear and breast exam? Results?

_____

If you did not already address previously on the first page, list any other gynecological exams or procedures you have had and the results.

_____

Do you feel that your libido is too high or too low?

_____

Describe any problems or concerns you may have regarding sexual function. Ex. pain during sex.

_____

8) OTHER

Is there any other problem or concern not previously mentioned that you would like to address?

_____

_____

_____

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Acupuncture on Eglinton for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Acupuncture on Eglinton may be conditioned upon my consent as evidenced by my signature on this document.

I understand l have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Acupuncture on Eglinton is not required to agree to the restrictions that l may request. However, if Acupuncture on Eglinton agrees to a restriction that l request, the restriction is binding upon Acupuncture on Eglinton.

I have the right to revoke this consent, in writing, at any time except to the extent that Acupuncture on Eglinton has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand l have the right to review Acupuncture on Eglinton's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Acupuncture on Eglinton. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners at Acupuncture on Eglinton with respect to my identifiable health information.

Acupuncture on Eglinton reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Cancellation Policy

Acupuncture on Eglinton does enforce a cancellation policy in order to better accommodate our patients. We appreciate your best efforts to be made to avoid unnecessary or last minute cancellations. If you do not cancel your appointment with at least 24 hours notice, you will be subjected to a **$50 fee**. There is no fee if you cancel or reschedule more than 24 hours prior to your appointment.

Your cooperation is greatly appreciated.

Patient Signature

Date