TRADITIONAL CHINESE MEDICINE AND ACUPUNCTURE INTAKE FORM

To assist in providing the best possible medical therapy with Traditional Chinese Medicine, please fill out this form as accurately and truthfully as possible. All information provided will be kept confidential and private in your patient file.

PATIENT INFORMATION

NAME:		TODAY'S DATE:
DATE OF BIRTH:	AGE:	SEX: M F
ADDRESS:		POSTAL CODE:
PHONE:	*EMAIL:	
OCCUPATION:		MARITAL STATUS: ___ M ___ S ___ D ___ W

* You agree that by providing this email address, and by initialling this document, that you have read the *Terms of Usage*, and agree that we can send you email communications to confirm appointments, provide exercise and health instructions, provide health updates, service updates, and send information through clinic newsletters. You can opt-out of this service at any time. _____ **(please initial)** _____ **(date)**

Terms of Usage: Email addresses are strictly confidential and are never given out to other sources. We believe in a no-spam policy. We use emails to confirm appointments, provide you with exercise, health updates and clinical newsletters. Email also provides you with a means of asking your practitioner questions when they are not able to answer phone calls while treating patients. At any time, you can choose to opt-out of our email informations services.

EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:
FAMILY PHYSICIAN:	PHONE:	NAME OF CLINIC:
Are you currently under a physician's care? YES NO	If YES, please describe for what condition or symptoms:	
List all prescription medications currently taking (including dosage if possible):		
List all non-prescription medications or supplements currently taking:		

Acupuncture is effective for a wide variety of health complaints, but what it truly excels at is wellness care. You need not have any particular complaints to receive acupuncture.

CHIEF COMPLAINT FOR INITIAL VISIT

CONCERN:	WHEN DID THE CONDITION DEVELOP?
1	
2	

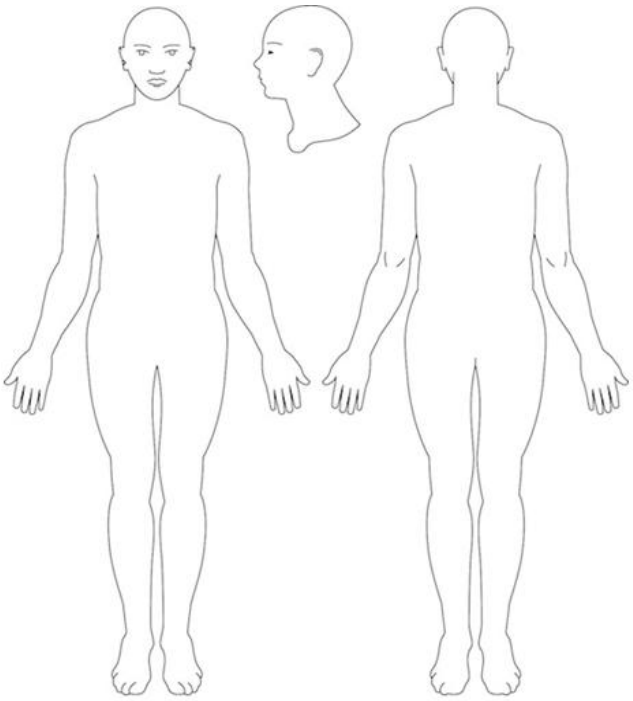
Have you been treated by other health professionals with respect to the condition you are seeking treatment for today? YES NO
If YES, please list which type of medical treatment you received: _____
Is your condition due to a car accident? YES NO Date of accident: _____

How did you hear about Dr. Kimberley Mintenko? _____ Referral: _____

PERSONAL MEDICAL HISTORY

HEIGHT:	WEIGHT:	BLOOD PRESSURE:
What is your level of activity? How much exercise do you do in a week?		
How would you describe your general state of health? Circle that which most accurately applies: EXCELLENT GOOD FAIR POOR		
Please list any past and/or current medical conditions that have been diagnosed by a certified medical professional, including date of diagnosis		
Please list history of hospitalizations, significant illnesses, or injuries, including dates		
Do you have any allergies? If YES, please list:		
Do you have a pacemaker? YES NO	Do you have any metal implants? YES NO	Have you had any medical tests recently? YES NO
Please circle any of the following conditions that you have been diagnosed with: HIV/AIDS HEPATITIS ATHEROSCLEROSIS BLOOD CLOTTING DISORDERS HEART ATTACK STROKE SHINGLES COPD		

Please indicate on the diagram where you are feeling pain:



How long have you been experiencing pain? _____
How would you rate the pain between 1-10
1 2 3 4 5 6 7 8 9 10

How would you describe the pain
- ___ Superficial
- ___ Deep
- ___ Burning
- ___ Distending/Wandering
- ___ Sharp
- ___ Dull
- ___ Aching
- ___ Fixed/Stabbing
- ___ Numb/Tingling

What makes the pain dissipate? _____
(ex. heat, ice, pressure, etc)

FAMILY MEDICAL HISTORY

Has yourself or anyone in your family been diagnosed with any of the following conditions? Circle all that apply

Alcoholism	Diabetes	Heart Disease	Cancer	Multiple Sclerosis
Alzheimer's Disease High	Cholesterol	Hypertension	Osteoporosis	Osteoarthritis
Depression	Epilepsy	Kidney Disease	Psoriasis	Eczema
Fibromyalgia	Mental Illness	Thyroid Disorder	Drug Abuse	Asthma

WOMEN'S HEALTH

Is there any chance you are currently pregnant? YES NO (If YES, at _____ weeks)	Are you currently trying to conceive?

Do you use birth control? If YES, what form of birth control do you use? (ex. condoms, oral contraceptives, IUD etc.):

PREGANANCY:
# of pregnancies _____ # of abortions: _____
# of births: _____ # of terminations: _____

Please describe any compilations with pregnancy:

MENSTRUATION:
Age of first menstruation: _____
Is your period regular? _____ Periods occur every: _____ days
First day of last period: _____ Periods last _____ days

MENOPAUSE:
Day of last period: _____
Symptoms (circle all that apply): Hot Flashes Vaginal Itching Night Sweats
Weight Gain Vaginal Dryness Weight Gain

Please describe the quality of menstruation (Circle):

Bright Red	Light Volume	Foul Odour
Dark Red	Heavy Volume	Clotting
Pale Red	Absent	Normal

Other: _____

PMS (please circle all that apply):

Mood Changes	Irritability/Anger	Anxiety	Insomnia
Forgetfulness	Fatigue	Dizziness	Bloating
Nausea/Vomit	Cravings	Weight Gain	Back Pain
Breast Tenderness	Headaches	Water Retention	Cramps

Do you have a history of sexually transmitted infections? If so, please indicate what and since when:

Date of last PAP smear, and if there were any abnormal findings:

Do you have any other women's health concerns? Please specify:

MEN'S HEALTH

Do have any problems with any of the following (check all that apply):

___ Decreased Libido	___ Ejaculation Disorders	___ Difficulty Urinating	___ Infertility
___ Erectile Dysfunction	___ Testicular Pain	___ Impotence	___ Enlarged Prostate

Do you have a history of sexually transmitted infections? If so, please indicate what and since when:

Date of last prostate exam, and if there were any abnormal findings:

Do you have any other men's health concerns? Please specify:

SYMPTOM CHECKLIST

CHEST & LUNGS	EYES, EARS, NOSE & THROAT	SLEEP & EMOTIONS	GASTROINTESTINAL	HEAD & SKIN
___ Shortness of Breath ___ Asthma ___ Wheezing ___ Pneumonia ___ Lung Infections ___ Weak Voice ___ Chronic Cough ___ Allergies ___ Palpitations ___ Anemia ___ Chest Pain/Tightness ___ Chronic Disease ___ Frequent Colds ___ Smoker * How many cigarettes/day? _____ * For how many years? _____ * Date quit: _____ * Body Temperature ___ Hot ___ Cold ___ Neither ___ Edema/Swelling ___ Heavy Limbs ___ Weak Limbs	___ Dry/Red/Itchy Eyes ___ Dull Eyes ___ Blurred Vision ___ Spots/Floaters in Eyes ___ Hearing Loss ___ Ringing In Ears ___ Cold Sores ___ Canker Sores ___ Sinus Issues ___ Nose Bleeds ___ Excess Mucus ___ Spontaneous Sweat ___ Night Sweat ___ Profuse Sweat ___ Slurred/Incoherent Speech * Preferred Flavour ___ Sour ___ Bitter ___ Sweet ___ Spicy ___ Salty * Do you feel thirsty? ___ Yes ___ No * Daily Fluid Intake: _____ * Preferred Temperature: ___ Hot ___ Warm ___ Cold	* # Hours of Sleep/Night: ____ ___ Insomnia ___ Difficulty Falling Asleep ___ Difficulty Staying Asleep ___ Waking to Urinate * # times/night: _____ ___ Nightmares * Rate your stress: ___ Minimal ___ Manageable ___ Unbearable * Where do you hold stress? _____ _____ _____ * How do you relax? _____ _____ _____ * Emotional State: ___ Joyful ___ Angry/Irritable ___ Worried/Anxious ___ Sad ___ Fearful ___ Jealous/Suspicious ___ Indecisive ___ Depressed ___ Restless * Daily Energy (between 1-10) _____	___ Poor/No Appetite ___ Insatiable Hunger ___ Bitter Taste in Mouth ___ Metallic Taste in Mouth ___ Belching ___ Nausea/Vomit ___ Vomit Blood ___ Acid Reflux/Heartburn ___ Frequent Urination ___ Difficult Urination ___ Incontinence ___ Burning/Painful Urination ___ Cloudy Urination ___ Blood in Urine ___ Frequent UTI ___ Kidney Stone * # Bowel Movements ____ per day/week —- Constipation ___ Diarrhea ___ Irregular ___ Well Formed ___Undigested Food ___ Loose Stool ___ Hard Stool ___ Mucus in Stool ___ Blood in Stool ___ Burning/Painful Stools ___ Bloating ___ Gas ___ Abdominal Pain	___ Headache * Location: ___ Forehead ___ Temporal ___ Occipital ___ Vertex ___ Whole Head ___ Migraines * Pain type? ___ Stabbing ___ Dull/Aching ___ Throbbing ___ Squeezing * What triggers them? _____ * What makes them better? _____ ___ Dizziness ___ Poor Memory ___ Body Weakness/Fatigue ___ Eczema ___ Psoriasis ___ Dandruff ___ Fungal Infections ___ Hives ___ Acne ___ Hair Loss/Thinning ___ Itching ___ Ulcers ___ Rashes

FOR PRACTITIONER USE

INITIAL TREATMENT

CC:			DATE:
T:	SYMPTOMS:		
P:			
	DIAGNOSIS:		

TREATMENT PLAN:

PRESCRIPTION:

TRADITIONAL CHINESE MEDICINE AND ACUPUNCTURE INFORMED CONSENT FORM

RISKS & BENEFITS OF ACUPUNCTURE AND TCM

Please read the following information and statements carefully, and clarify any questions with your practitioner.
While the practice of Traditional Chinese Medicine, Acupuncture, Moxa, Cupping, Electro-Acupuncture, and Gua Sha are considered to be safe treatments, as a patient, you should be aware of the following side effects that may occur:

- Potential Benefits (including, but not limited to): drugless relief of presenting symptoms, improved body balance that may lead to the prevention, improvement, or elimination of presenting symptoms
- *Residual needle sensation:* the sensation may last post-treatment that will dissipate within 1-2 days
- *Drowsiness or dizziness:* please eat and drink before treatment (avoid large heavy meals, alcohol, or caffeine), as these effects may be more common with hunger or dehydration. It is recommended not to drive or operate equipment immediately after treatment. Do not exercise just before or after a treatment. Do drink plenty of water after a treatment.
- *Fainting:* may be more common with hunger, dehydration, or upon your first acupuncture treatment. Please communicate with your practitioner to prevent this effect as much as possible.
- *Bruising or bleeding:* may occur at insertion site or where cupping was performed; discolouration will dissipate from a few hours to as long as 2 weeks. Please advise your practitioner if symptoms worsen or are severe.
- *Temporary aggravation of symptoms:* with many types of healing, symptoms may worsen before improvement is seen. Please advise your practitioner if symptoms worsen for more than a few days.

Herbal products used in Traditional Chinese Medicine (which may consist of plant, animal, or mineral source) that have been recommended to me are considered safe. Some adverse interactions may occur while taking other medications or during pregnancy, therefore it is important to keep your practitioner informed of these situations or conditions. Possible side effects to herbal therapy may include gastrointestinal upset, or skin rashes.

STATEMENT OF CONSENT TO TREATMENT & CONTACT

As a patient of Dr. Kimberley Mintenko, I have read the above information and understand that this form of medical care is based in Traditional Chinese Medicine principles and practices to benefit my health and wellness. I attest that all information provided to my acupuncturist is complete and true. Dr. Kimberley Mintenko uses therapeutic techniques outlined by Traditional Chinese Medicine theory; however, I understand the diagnosis and treatment by Dr. Kimberley Mintenko does not replace that of a physician or dentist and I understand all the risks and benefits associated with this treatment. In accordance with Section 8(1) of Alberta's Acupuncture Regulation, I have consulted with a physician or dentist for my condition prior to receiving acupuncture treatments, or agree to seek consultation before any future acupuncture treatments.

I understand the risks and benefits of acupuncture as explained to me and give consent to receive treatments by a registered acupuncturist, taking full responsibility for the outcome of treatments. I also understand and give consent for medical information to be shared between practitioners at Kinetic Health in the interest of my best course of health care. I have been informed that side effects may occur from acupuncture or herbal therapy and agree to discontinue use and inform my practitioner immediately if these occur. I will also inform my practitioner immediately if I become pregnant or any other health conditions develop. I understand it is my responsibility to fully disclose all medications I may be taking, and refrain from mixing these medications with any prescribed herbal formulas.

I hereby provide consent to acupuncture, herbal therapy, and any other modalities for treatment within the scope of Traditional Chinese Medicine as seen fit by Dr. Kimberley Mintenko. I also confirm that I am of sound mind and have the ability to accept or reject this care and treatment protocol of my own free will and choice. I accept full responsibility for fees incurred during treatments.

Name (please print): _____

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

24 hours notice is required to avoid billing for cancelled or missed appointments.