



SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
 Tel: 403.455.8029 Email: south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3
 Tel: 403.984.3970 Email: north@holisticinstitute.ca

ACUPUNCTURE PATIENT INTAKE FORM

Date:					
Surname:		Pref Name:			
Date of Birth (M/D/Y):		Age:		Gender Pronoun:	
Address:					
City:		Province:		Postal Code:	
Family Doctor:					
Business Employer:		Occupation:			

Phone/Contact Information

Home:		Business:			
Cell:		Email:			

How were you referred to us?

Have you heard about our HIHF health PROGRAMS? _____yes _____no

Would you like more information? _____yes _____no

Please provide the reason for your visit:

Have you consulted with a physician or dentist (as appropriate) about the condition for which treatment is now being sought?

What was their diagnosis?

Is there anything that makes it better?	
Is there anything that makes it worse?	



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A MEDICAL HISTORY		
<i>List any medications or nutritional supplements that you are currently taking:</i>		
Name of Medication/ Supplements	Used for?	For how long?

Personal Health History (*Please check any conditions or symptoms that apply to you*)

- | | | |
|---|--|---|
| <input type="checkbox"/> Addiction (s) | <input type="checkbox"/> Aids | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis-Rheumatoid/Osteo | <input type="checkbox"/> Asthma | <input type="checkbox"/> Candida |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Chronic Pain Condition |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Cholesterol Issues |
| <input type="checkbox"/> Common Allergies | <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Hypo / Hyperglycaemia | <input type="checkbox"/> IBS | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Kidney Issues |
| <input type="checkbox"/> Liver / Gall Bladder Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> TB | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Ulcer |

<input type="checkbox"/> Cancer type:	
<input type="checkbox"/> Food Allergies /Intolerance:	
<input type="checkbox"/> Other:	



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GYNAECOLOGICAL / REPRODUCTIVE HISTORY			
Birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long?	
Age of first period?		Date of your last period?	
Duration of period? (days)		Length of cycle? (days)	
Are cycles regular?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful menses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How heavy is your bleeding?	<input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy		
What color is the blood?	<input type="checkbox"/> Light red <input type="checkbox"/> Red <input type="checkbox"/> Dark Red <input type="checkbox"/> Purple <input type="checkbox"/> Brown <input type="checkbox"/> Black		
Is there clotting? If yes, are they	<input type="checkbox"/> big clots <input type="checkbox"/> small clots		
Do you bleed or spot in between periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you pregnant, if "yes" how many weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No Number of weeks_____		
Do you have a midwife, OBGYN, Doula?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast pain, lumps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endometriosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cervical Dysplasia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ovarian cysts, fibroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
How many children do you have?	Number:	Years:	
How many pregnancies have you had?	Number:	Years:	
How many abortions have you had?	Number:	Years:	
How many miscarriages have you had?	Number:	Years:	
How many times has a D&C been performed?	Number:	Years:	
Have you ever had an abnormal pap smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had a venereal disease? Name of disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you get yeast infections regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had pelvic inflammatory disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed with any pelvic abnormalities?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you get premenstrual back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do your bowel movements become loose at the beginning of your period?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Menopausal symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

GENERAL TCM HEALTH HISTORY

During the day do you feel:

- Chills Fever Both
- Perspiration when not active

Do you prefer to drink:

- Warm / hot fluids Cold fluids

Are you frequently thirsty?

- Yes No Sometimes

How much water do you drink in a day?

How is appetite?

- Good Normal Poor
- I experience "gnawing hunger"

After eating do you experience?

- bloating gas acid regurgitation
- fatigue / sleepiness cravings for sweet / salty

At night, I:

- have difficulty falling asleep
- have difficulty staying asleep – if so, what times are you waking up?
- have dreams that wake me up
- waking feeling hot / sweaty
- feel anxious*
- have heart palpitations*

**Please indicate if during the day too*

Urine:

- I wake during the night to urinate
- I urinate first thing when I awake
- unusual color
- unusual odour
- any mucus in your urine?
- any burning sensation?
- do you have frequent urination?
- have an urgency to urinate?

Bowel Movements:

- constipated diarrhea both
- frequency unusual odour mucus
- runny dry
- urgency to go first thing in the a.m.

Pain? Please describe if sharp, dull, achy, hot, cold, shooting, moving

- in your back lower, middle, upper
- in your knees
- tension in your shoulders / neck
- headaches – what areas of head?
- migraines – caused by the change in weather?
- in your heels when you walk
- shoulders
- arms
- hands
- legs
- feet
- other

Respiratory?

- any breathing difficulties

Hair / Teeth / Eyes?

- have you experienced hair / teeth loss?
- premature greying?
- do you clench or grind your teeth?
- do your eyes get dry, blurry, strained when tired?
- do you see floaters?

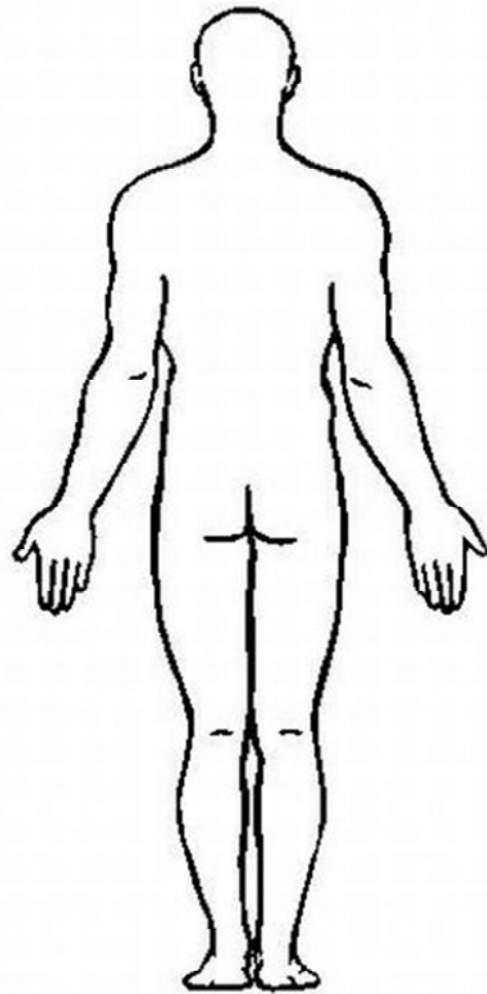
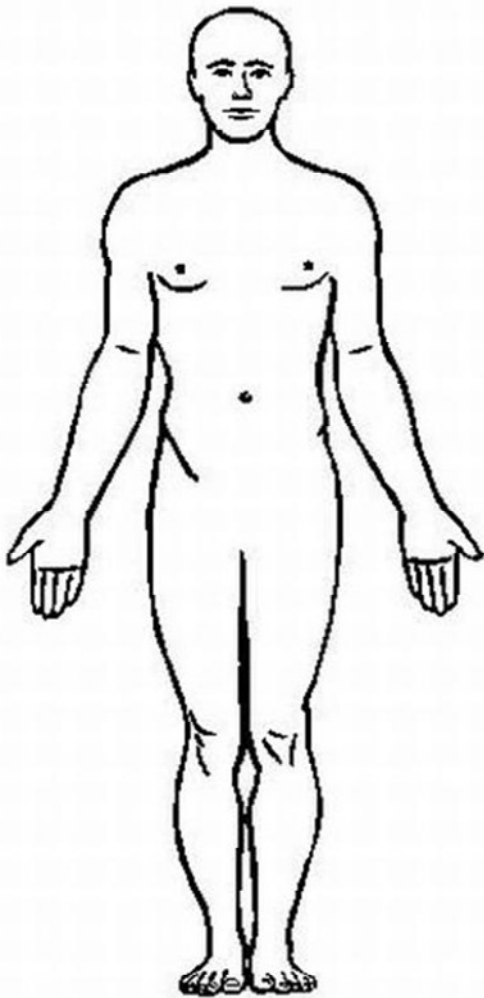
Energy?

- are you frequently tired
- have normal energy levels
- better than normal

Office use only

PULSE R		PULSE L		TONGUE	
LU		HT			
SP		LV			
KI YANG		KI YIN			

Please CIRCLE areas of pain/ discomfort





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HIHF CLINIC CANCELLATION POLICY

We understand at the Holistic Institute of Health and Fertility (HIHF) that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

We want to be available for your needs and the needs of all our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours notice, you will be charged the **FULL FEE**.

MasterCard, Visa and American Express are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the HIHF clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: _____ Printed Name: _____

Date: _____

Signature of Parent or Guardian if the Patient is under 18 years of age: _____

HIHF CLINIC WAIVER

I understand that it is my choice to be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Holistic Institute of Health and Fertility (HIHF) is based on traditional Chinese medicine, and/or therapeutic massage, and/or yoga principles only and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking. I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I understand clinic staff may review my records but all information will be kept confidential and will not be released without my written consent. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am concurrently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am concurrently taking. I assume all risks and responsibilities for myself and release HIHF clinic and its agents from any injury or liability that may occur during a treatment session.

Please sign and date below to indicate that you have read and understood this form.

Signature: _____ Printed Name: _____

Date: _____

Signature of Parent or Guardian if the Patient is under 18 years of age: _____