HOLISTIC INSTITUTE OF Health & Fertility

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 PRENATAL 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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MEDICAL HISTORY

List any medications or nutritional supplements that you are currently taking:

Name of Medication/Supplement	Used for?	For how long?

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

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

❒ Cancer type:	
❒ Food Allergies /Intolerance**:**	
❒ Other:	

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

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PRENATAL QUESTIONAIRE

Pregnancy profile – please check/circle/fill in the following information to give us a detailed picture of your pregnancy.

I am in my first in my 1st/2nd/3rd trimester

I am _____ wks My Due Date is _____

I am planning to have my birth at _____

This is my (1st/2nd/3rd /4th …?) _____ pregnancy

I am under the care of the following health care providers (OBGYN/Midwife/Doula)

_____

Have there been any issues/concerns with any of your check-ups so far? If so please explain

_____

I am currently experiencing the following: (please circle applicable items)

Nausea / vomiting / dizziness
Fatigue
Stress / worry / fear
Sleep disturbance
Swelling
Cramping
Spotting
Gestational Diabetes
High/ Low Blood Pressure
Shortness of breath
Difficulty walking/sitting/standing

<u>Pain</u>
Under the ribs;
In my low back/pelvis/pubic bone
On the sides of my hips
In my arms / legs
In my neck
Across my shoulders/between my shoulder blades
Tension/pulling under my belly
Other (please explain)

_____
_____

The position of my baby is: Head down / Transverse / Breech / Unknown

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PRENATAL QUESTIONAIRE

Describe your previous birth experience

Vaginal delivery / C-section / vacuum / forceps _____

Episiotomy _____

Induction _____

Epidural _____

Labour time _____

Baby weight _____ length _____

Breastfeed _____ for how long? _____

Have you been diagnosed with any health conditions as a child or through your adult life? Please list

_____

Please describe any over the counter or prescription medications you are currently taking

_____

Please list all supplements/vitamins that you are currently taking

_____

Do you have any specific concerns you'd like us to address?

_____

Can we provide you with more information about Prenatal-

Acupuncture / Massage / Chiropractic / Nutrition / Yoga / Counselling / Doula support/ post-partum support / lactation consulting / Prenatal classes /

Other resources

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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**			

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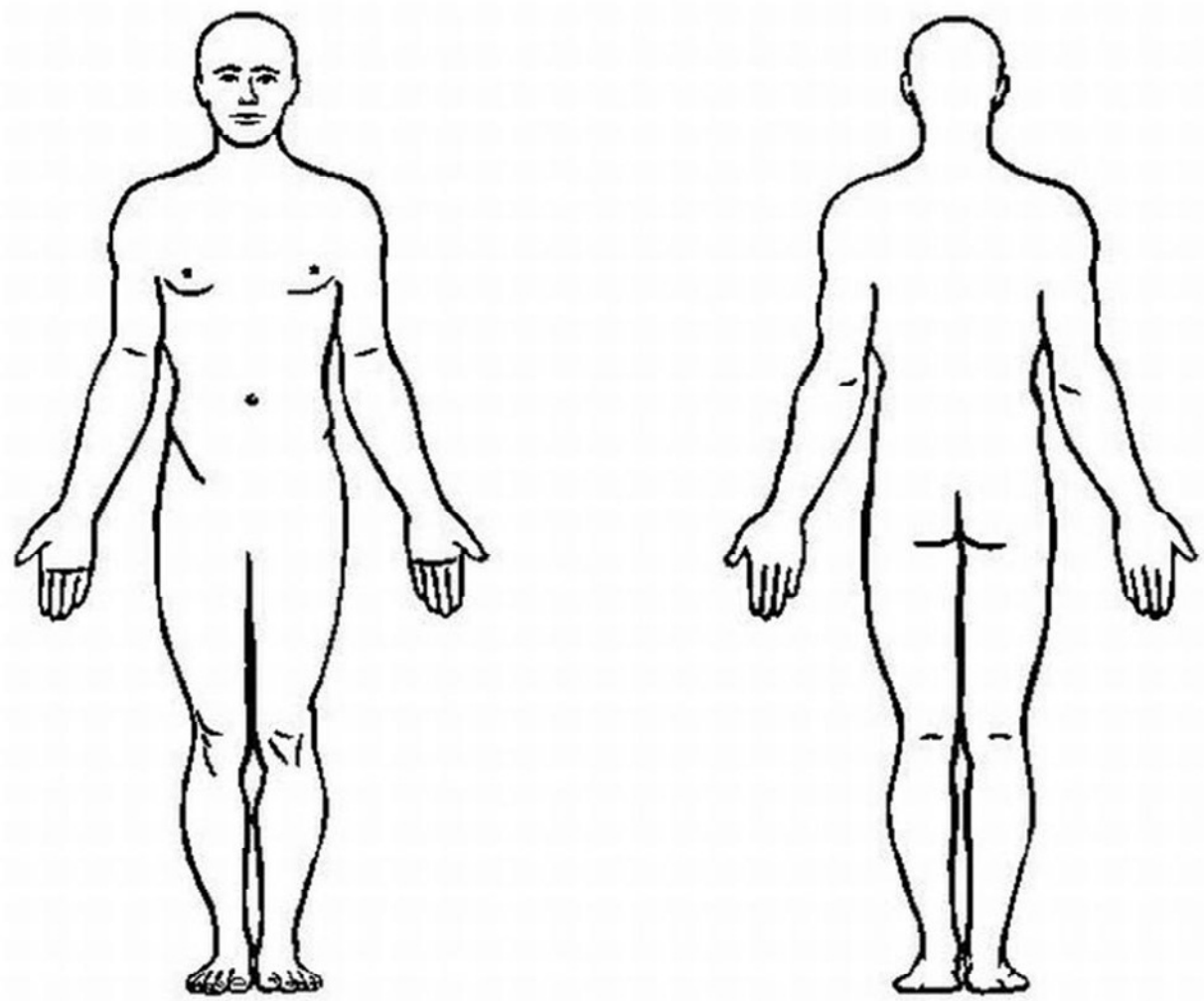
Please CIRCLE areas of pain/ discomfort



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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 I should 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: _____