Heartwood Acupuncture & Wellness
New Patient Intake Form

Please note that all information is strictly confidential.

Today's Date _____

General Information

Name _____ Age_____
Address _____ City_____
Phone # to reach you _____ Alternate Phone _____
Date of Birth _____ Email Address _____
Occupation _____
Emergency contact name _____ Relationship_____Phone _____
Who should we thank for referring you to this office?_____

A Few Important Questions:

1. Have you had acupuncture before? No__ Yes___ When?_____
2. Are you pregnant, or is there any chance that you could be pregnant? Yes __ No __
3. Do you have any allergies or intolerances to food, medications or other substances? Yes__No___
   If so, please list them: _____
4. Do you have a pacemaker? Yes ___ No ___

Reasons for Today's Visit:

Issue	How, When, Where it First Started	What Makes It Better? Worse?

Your Medical History:
Please list any medications (prescription or over-the-counter), supplements/herbs you are currently taking:

Please list any diseases or disorders that you have been diagnosed with: Year diagnosed

Please list any past injuries, illnesses, surgeries or past hospitalizations:
Year

Please list Immediate Family Medical History (Mother, Father, Siblings):

Please print, complete, and email forms to info@heartwoodwellness.com before your initial appointment. Thank you.

Your current condition (over the past days/weeks)

What is your energy level? Low ___ Normal ___ High ___

Digestion:

How is your appetite? Low ___ Normal ___ Voracious ___

Any specific taste in your mouth? No ___ Metallic ___ Bitter ___

Bowel movements:

How often do you have a BM? Twice/day ____ Once/day _____ Once/2-3 days ___ Once/4-5days ____

How is it shaped? One piece __ Chunks __ Pebbles __

What colour is it? Brown __ Green __ Black __ Reddish __

What tone is it? Normal __ Light __ Dark __

What quality is it? Normal __ Hard __ Soft/creamy __ Loose/diarrhea __

What does it smell like? Normal __ Strong bad smell __

Any other contents? None __ Undigested food particles __ Blood __ Mucous __

How is its passage? None __ Painful __ Tired after BM ___ Burning Sensation __

Urination:

How often do you urinate? _____ times/day Comments:

What is the volume? Normal __ Low __ High __

What tone is it? Normal __ Light __ Dark __

Any specific smell to it? None __ Sweet __ Other _____

What quality is it? Clear __ Cloudy __ Reddish __ Other _____

How is its passage? Normal __ Burning __ Painful __ Wait to start flow __

Takes a minute to start __Dribbles after you finish __Feels very urgent/hard to hold__

Average Diet:

Breakfast: _____ Time eaten: _____

Lunch: _____ Time eaten: _____

Dinner: _____Time eaten: _____

Caffeine: Yes __ If yes, # of cups/day: _____

Alcohol: Yes __ If yes, # of drinks per week: ____

Tobacco: Yes __ If yes, # of cigarettes/day: _____

Other recreational drugs (pot, other): If yes, at what frequency? _____

Any specific food/flavour/drink cravings? If yes, what are they? _____

Body Temperature:

What is your average body temperature? Chilled __ Cool __ Normal __ Warm __Hot __

Any specific time of day you feel specific temperatures (e.g. hot at night)?

Do you tend to have cold hands?___ Cold feet? ___

Exercise:

Do you do any regular kind of exercise?

If yes, what? _____

If yes, how often? Every day ___ 3-5 times/week ___ 1-2 times/week ___ A few times/month ___

Work:

Do you enjoy your work? Yes___ No____

How many hours per week do you work? _____

Do you currently have or have had any of the following?:

Anemia Epilepsy Fibromyalgia Arthritis Diabetes Multiple Sclerosis Emotional Disorders Drug Problem Digestive Disorders Heart Problem Tuberculosis Cancer Hepatitis HIV Allergies High Blood Pressure Kidney Disease Osteoporosis Asthma Stroke Ulcers Thyroid Problem Kidney Stones Gall Stones Alcoholism AIDs

Please check any of the symptoms you are experiencing now or have had in the past. While some may seem irrelevant to what you want to be treated for, this information is very important to discovering a whole-body pattern in Traditional Chinese Medicine.

Please write N or P below: N = Now
P = Past
N & P = Now & Past

Head & Neck

Dizziness ___ Light-headed upon standing ___ Migraines ____ Headaches____ Stiff neck ____
Memory loss ____ Fainting ___ Swollen glands ___ Thinning hair ___ Hair loss___ Foggy thinking ___

Eyes

Blurry vision ____ Poor night vision ____ Spots or floaters ____ Eyelid twitching ____
Inflammation ____ Styes ____ Double vision ____ Cataracts ____ Glaucoma ____ Eye pain ____
Red Eyes___ Dry, irritated eyes ___

Ears

Ringing in the ears ____ Hearing loss ____ Ear infections ____ Ear aches ____ Hearing aides ____
Vertigo _____

Face, Mouth & Throat

Frequent colds___ Sinus infections___ Nose bleeds___ Hay fever/ allergies __ Chronic congestion __
Sore throat ___ Hoarseness ___ Loss of voice ___ Difficulty swallowing ___ Dental problems ___
Tongue/mouth sores ___ Gum problems ___ Teeth grinding ___ TMJ___ Changes in taste __
Facial pain ____ Dry mouth __ Dry throat ___ Dry nose ___ Frequently flushed face ___
Enlarged lymph nodes ___

Respiratory

Asthma ____ Wheezing ____ Cough ____ Lung congestion/phlegm ____ Shortness of breath ____
Tight chest ____ Difficulty breathing ____ Pneumonia ____ Daytime sweating ____ Night sweats ____

Skin

Acne ___ Dryness ____ Itchiness ____ Changes in moles/or lumps ____ Rashes ____
Eczema ____ Psoriasis ____ Hives ____

Neurological

Tremors ____ Seizures ____ Nerve pain ____ Numbness or tingling ____

Cardiovascular

High blood pressure ____ Low blood pressure ____ Chest pain ____ Chest tightness ____
Palpitations/racing heart ____ Irregular heartbeat ____ Poor circulation ____ Swollen ankles ____
Easy bruising/bleeding ____ History of heart attack ____ Raynaud's Syndrome ____ Afternoon fever___

GI

Hiccups ____ Sighing frequently ____ Nausea ____ Gas ____ Bloating ____ Heartburn/acid reflux ____
Abdominal pain ____ Bad breath ____ Rectal bleeding ____ Hemorrhoids ____ Fatigue after eating___
Ravenous appetite___ Belching/vomiting___ Thirsty____ Early morning diarrhea___ Feeling heavy___

Musculoskeletal

Joint pain ____ Abnormal muscle weakness ____ Stiff neck/shoulders ____ Low back pain ____
Sciatica pain ____ Sore/cold/weak knees____ Heat in palms/soles___

Emotions

Anger ____ Irritability ____ Depression ____ Suicidal tendencies ____ Overthinking ____ Worry ____
Fear ____ Anxiety ____ Restlessness___

Sleep

Hard to fall asleep ____ Hard to stay asleep ____ Don't feel rested in morning ____ Vivid dreams ____
Hours of sleep per night? _____ Wake to urinate more than once during the night_____ Insomnia___

Women's Health

At what age did you have your first period? ____ years old
Have you reached menopause? Yes __ No __
(Age of onset: ___ years old / Age of completion: ___ years old)
How many days is your overall cycle? ____ days
(Counting from Day 1 of your period to the next month's period – e.g. 28 days)
How regular is the length of your cycle? Regular/steady __ Irregular/fluctuating by month __
How many days is your average period? (e.g. 5 days) ____ days
Amount of blood: Light flow __ Normal flow __ Heavy flow __
Quality of blood: Thick __ Normal __ Thin __ Watery __
Colour of blood: Red __ Brown __ Pink __ Other _____
Tone of blood colour: Light __ Normal __ Dark __
Smell of vaginal discharge? None __ Fishy __ Leathery __
Clots? No __ Yes __
If yes, what size? Dime-sized ___ Nickel-sized ___ Quarter-sized __ Loonie-sized__ Larger __
PMS? No __ Yes __ If yes, what are your symptoms?
Lower abdominal cramps___ Breast tenderness___ Pain under ribs___Low back pain___
Headaches___ Water retention/swelling___ Frequent sighing___ Fluctuating emotions__
When do you have these symptoms?
From ____ day(s) before my period until ____ day(s) after my period starts.
Do you use birth control? No __ Yes __
If yes, what type/brand? _____
# of pregnancies: _____ # of deliveries: _____ # of abortions: _____ # of miscarriages: ____
Check any other gynecological issues you have had:
Fibroids __ Breast pain __ Polyps __
Cysts __ Breast lumps __ HPV __
Frequent UTIs __ Decreased libido __
Endometriosis __ Increased libido __ Fibrocystic breast disease __
Cystitis __ Vaginal infections __ Abnormal bleeding __
Yeast infections __ Nipple discharge __
Abnormal pap smear __ Painful/itchy genitalia __
Pelvic inflammatory disease __ Other:_____

Men's Health

Date of Last Prostate Checkup:_____Results:_____
Circle all that apply:
Groin Pain Testicular Itching Testicular Lumps Enlarged Prostate Decreased Libido Increased Libido Painful Urination Difficult Urination Dribbling Urination Nocturnal Enuresis Incontinence Premature Ejaculation Nocturnal Emissions Impotence Erectile Difficulty

Other:_____
_____
_____

Thank you for answering all these detailed questions!

Heartwood Acupuncture & Wellness

MONIKA KONIECZKA, R.AC (778) 886-0880

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur.

What are the possible side effects of acupuncture and electroacupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Unusual risks of acupuncture include pneumothorax and organ puncture.
- Fainting can occur in certain patients, particularly during the first treatment.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

What are the possible side effects of other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping and Gua-Sha;
- Slight superficial burns are a possible side effect of Moxibustion.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand that my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our patients from their visit to Heartwood Wellness is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Heartwood Wellness, unless, in the best interest of the patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Heartwood Wellness (also, Heartwood Wellness will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the patient. The patient information will be stored both in digital and hard copy format on Heartwood Wellness premises. On occasion, Heartwood Wellness may use patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

Welcome to Heartwood Acupuncture & Wellness Center. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy. Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid being charged the full appointment fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

_____

Print name in full

_____ _____

Signature Date

Please print, complete, and email forms to info@heartwoodwellness.com before your initial appointment. Thank you.