

Initial Intake

This is a CONFIDENTIAL questionnaire to help me determine the best-individualized treatment plan for you. If you have any questions, please ask. Thank you, Francis Rock.

Personal Information

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____

Occupation: _____

Person responsible for your account: _____

Sex: Male Female

Height: _____ Weight: _____ Birthdate: _____ Age: _____

Have you ever received acupuncture before? Yes No

If yes - When? _____ With whom? _____

Have you ever taken Chinese herbs before? Yes No

If yes - When? _____ With whom? _____

Whom were you referred by? _____

What are the main health problems which you are seeking treatment? _____

What other forms of treatment have you sought? _____

List any other health problems you now have? _____

List any allergies, food sensitivities, or food cravings that you have? _____

List any accidents, surgeries, or hospitalizations (include date). _____

Lab Results: _____

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Suite 402
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Tel: 416.960.9001

AKUKLINIK



Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases:

- AIDS Chlamydia Gonorrhea Herpes
 HPV Syphilis _____ Date

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last checkup

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	HowMuch
Coffee/Black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____



How do you FEEL about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

For Women

Age of 1st period (menarche) _____	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of pregnancies _____
Age of last period (menopause) _____	# of live births _____	# of abortions _____
Number of days between periods _____	Date of last: GYN Exam _____	Pap Smear _____
Number of days of flow _____	Mammogram _____	Bone Density Scan _____
Color of flow _____	Results: _____	

Clots? Yes No Color _____

Average number of pads you use per day: _____

Location of pain:	<input type="checkbox"/> Lower abdomen	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Thighs	<input type="checkbox"/> Other _____
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Nature of Pain (please indicate before, during or after menses)

Cramping _____	Stabbing _____	<input type="checkbox"/> Discharge	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Headache
Burning _____	Aching _____	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
Dull _____	Bloating _____	<input type="checkbox"/> Swollen Breasts	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Ravenous appetite
Consistent _____	Intermittent _____	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats
Bearing down sensation _____		<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Insomnia

Other symptoms related to menses _____

Have you ever been diagnosed with:

Fibroids
 Fibrocystic Breasts
 Endometriosis
 Ovarian Cysts
 PID Other _____





Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark () = never experience Check mark (√) = sometimes experience
plus sign (+) = frequently experience

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> eye problems | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> chest pain | <input type="checkbox"/> easily bruised | <input type="checkbox"/> edema |
| <input type="checkbox"/> loose stool or diarrhea | | <input type="checkbox"/> sciatic pain | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> jaundice (Yellowish eyes or skin) | | <input type="checkbox"/> headaches | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> digestive problems, indigestion | | <input type="checkbox"/> black tarry stools | |
| <input type="checkbox"/> pain or coldness in the genital area | | <input type="checkbox"/> difficulty digesting oily foods | |
| <input type="checkbox"/> difficult to stop bleeding | | <input type="checkbox"/> gall stones | <input type="checkbox"/> angina pains |
| <input type="checkbox"/> belching, burping | <input type="checkbox"/> urinary problems | <input type="checkbox"/> light colored stool | <input type="checkbox"/> asthma |
| <input type="checkbox"/> heartburn/reflux | <input type="checkbox"/> cough | <input type="checkbox"/> soft brittle nails | <input type="checkbox"/> allergies |
| <input type="checkbox"/> shortness of breath | | <input type="checkbox"/> tendency to catch colds easily | |
| <input type="checkbox"/> feeling of claustrophobia | | <input type="checkbox"/> easily angered or agitated | |
| <input type="checkbox"/> difficulty in making plans or decisions | | <input type="checkbox"/> intolerance to weather changes | |
| <input type="checkbox"/> feeling the retention of food in the stomach | | <input type="checkbox"/> decreased sense of smell | |
| <input type="checkbox"/> tendency to become obsessive in work, relationships | | <input type="checkbox"/> spasms or twitching of muscles | |
| <input type="checkbox"/> skin problems | <input type="checkbox"/> nasal problems | <input type="checkbox"/> bronchitis | <input type="checkbox"/> hay fever |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> low back pain | <input type="checkbox"/> tendency to faint easily | |
| <input type="checkbox"/> insomnia, difficulty sleeping | | <input type="checkbox"/> high cholesterol levels | |
| <input type="checkbox"/> heart palpitations | <input type="checkbox"/> constipation | <input type="checkbox"/> hearing impairment | |
| <input type="checkbox"/> cold hands and feet | | <input type="checkbox"/> sudden weight loss | |
| <input type="checkbox"/> ear ringing | <input type="checkbox"/> knee problems | <input type="checkbox"/> colitis or diverticulitis | |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> kidney stones | |
| <input type="checkbox"/> mentally restless | <input type="checkbox"/> hair loss | <input type="checkbox"/> decreased sex drive | |
| <input type="checkbox"/> laughing for no apparent reason | | <input type="checkbox"/> recent use of antibiotics | |



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, Chinese Medicine 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. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- 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 or 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;
- Fainting can occur in certain patients, particularly at 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.



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 the practitioner may review my medical records and lab reports, but all 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.

Print name in full

(Print name of representative if represented by another)

Signature

(Signature of Representative)

Date



Cancellation Policy

Welcome to Akuklinik Centre for Integrated Health. 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 your treatment has been reserved for you, whereas most medical offices overbook by appointing several patients at the same time. Scheduling multiple patients provides the practitioner with a steady flow of patients but does not respect the patient's time.

Occasionally, there is a problem with patients who are not used to staying on schedule themselves. If you are going to be more than 15 minutes late, please call to confirm availability.

A 24 hour notice period is required to cancel or reschedule an appointment in order to avoid a cancellation fee of \$80. This allows us time to reschedule another patient that would benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours

Any questions regarding my appointments have been addressed. I have read this statement and fully understand it.

(Print name in full)

(Signature)

Date