LAINEY NOREN-STONE, R.AC **Acupuncture New Patient Form** CONFIDENTIAL

We not discriminate or deny care based on history, body type or identity. We aim to be an equal partner in your health care.

Name:	Legal Name (for emergencies/insurance)
Date of Birth: DD / MM / YYYY	Occupation:
Phone:	Please **do not** leave voice mail messages ☐
Address:	
Email:	Please do not contact me by email ☐
Emergency Contact (name and phone):	
How did you hear about us?	Have you been treated with acupuncture before? Y ☐ N ☐ Have you been treated with other complementary medicine? Y ☐ N ☐

Main Concerns

1). _____

When did this start? _____

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild)0|----------|----------|10(severe)

2). _____

When did this start? _____

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild)0|----------|----------|10(severe)

3). _____

When did this start? _____

Heat makes it: better | no change | worse

Cold makes it: better | no change | worse

Exercise/Activity: better | no change | worse

1 (mild) |----------|----------| 10 (severe)

Health History

	You	Family		You	Family
Cancer	☐	☐	Gender Reassignment	☐	
Type: _____			Asthma	☐	☐
Lung disease	☐	☐	Osteoporosis	☐	☐
Heart disease	☐	☐	Diabetes	☐	☐
Blood Pressure	☐	☐	Type: _____		
High	☐	☐			
Llow	☐	☐	Anemia	☐	☐
Pacemaker	☐	☐	Thyroid	☐	☐
Stroke	☐	☐	high ☐ low ☐		
Kidney disease	☐	☐	Mental health	☐	☐
Liver disease	☐	☐	Type: _____		
High Cholesterol	☐	☐	Bleeding/clotting disorder	☐	☐
Hepatitis	☐	☐	Seizures	☐	☐
HIV/AIDS	☐	☐	Dizzy/fainting	☐	☐
Other STI	☐	☐	Addiction	☐	☐
Type: _____			Type: _____		

Other:

_____

Do you follow a special diet?
Y ☐ N ☐
Describe:

Do you exercise regularly?
Y ☐ N ☐
Describe:

	Amount	Quit
Sugar		
Caffeine		
Tobacco		
Other		

Medications
Note drugs, hormones, supplements you take regularly

Body Temperature Cold |----------|----------| Hot	○ Cold hands/feet ○ Chills ○ Numbness ○ Like hot drinks	○ Excessive thirst ○ Thirsty, but no desire to drink ○ No thirst	○ Hot hands/feet ○ Hot flashes When? _____ ○ Like cold drinks	○ Unusual sweats When? _____ Where? _____ ○ Don't sweat
Moisture Oily |----------|----------| Dry	○ Dry skin ○ Dry hair ○ Brittle nails ○ Dandruff	○ Dry mouth ○ Dry lips ○ Dry throat ○ Dry nose ○ Nosebleeds	○ Oily skin ○ Oily hair ○ Acne Where? _____	○ Swelling/edema ○ Itching/rashes ○ Psoriasis ○ Eczema
Digestion Loose |----------|----------| Dry stool stool	○ Constipation ○ Diarrhea ○ Loose stools ○ Tired after BM ○ Blood or mucous	○ Difficulty ○ Hemorrhoids ○ Foul smelling ○ Gall stones	○ Gas/bloating ○ Bad breath ○ Heartburn/belching ○ Nausea ○ IBS	○ High appetite ○ Poor appetite ○ Weight gain ○ Weight loss ○ Food cravings

Energy Low |----------|----------| High	○ Sudden energy drop ○ When? ○ Tired after eating ○ Ungrounded feeling	○ Shortness of breath ○ Heart palpitations ○ Bruise easily ○ Body feels heavy/weak	○ Poor concentration ○ Poor memory ○ Headaches ○ Lightheaded/dizziness

Eyes/Ears/Nose/Throat	**Emotions**	**Sleep**	**Reproductive Health**
○ Poor vision ○ Night blindness ○ Red eyes ○ Itchy eyes ○ Floaters ○ Sinus congestion ○ Phlegm ○ Cough ○ Sore throat ○ Poor hearing ○ Ear ringing ○ Excessive earwax ○ Dental problems ○ Mouth sores ○ TMJ ○ Grind/clench teeth Other: _____	○ Anger ○ Irritability ○ Anxiety ○ Worry ○ Obsessive thinking ○ Grief ○ Depression ○ Easily excitable ○ Easily startled ○ Fear ○ Timid/shyness ○ indecision	# hours per night? ____ ○ Trouble falling asleep ○ Wake _____ x / night When?_____ ○ Wake to urinate? How often?_____ ○ Disturbing dreams ○ Restless sleep ○ Not rested ○ Hot flashes	Sexually active? Y □ N □ ○ Change of sexual drive Increase ___ Decrease ___ ○ Infertility ○ Vasectomy ○ Hysterectomy Partial ___ Full ____ ○ Hormone therapy ○ Prostate problems ○ Erectile dysfunction ○ Premature ejaculation ○ Candida/yeast infections
	Stress Low |----------|----------| High	**Urinary Health** Fluid in=Fluid out? Y □ N □ ○ Decreased flow ○ Dribbling ○ Incontinence/urgency ○ Increased frequency	○ Kidney/bladder stones ○ Pain on urination ○ Burning ○ Cloudy ○ Blood in urine

Menses			**Menopause**
Are you pregnant? Y □ N □ Contraception? Y □ N □ Type:_____ Age of first menses:_____ # of pregnancies: _____ # of miscarriages/abortions:_____ Average # days of flow: _____ Average # days of cycle:_____ Is your menses cycle regular? _____ Flow is: Normal__ Heavy__Light___	Colour is: Red __ Dark___ Bright__ Purple___ Brown__ ○ Cramps ○ Clots ○ Nausea ○ Low back pain ○ Breast tenderness ○ Mood changes ○ Pain with intercourse ○ Difficulty with orgasm	○ Fatigue ○ Sleep changes ○ Digestive changes ○ Bloating ○ Cravings ○ Bleeding between periods ○ Abnormal Pap ○ Vaginal discharge	Age of last menses: _____ Year changes began: _____ ○ Hot flashes ○ Night sweats ○ Vaginal dryness ○ Change in libido ○ Memory changes ○ Other:

INFORMED CONSENT

I hereby request and voluntarily consent to receive Oriental Medicine treatments for my present and future health conditions. I understand that treatment will be administered by a Registered Acupuncturist (R.Ac).

Acupuncture is just one form of therapy that may be used in the course of a treatment. Other procedures that may be used in the course of treatment include: the use of bodywork (tuina massage, cupping, gua sha (scraping), acupressure), Shi liao (food therapy), heat therapy (TDP lamp, moxibustion [burning mugwort herb]) and/or acupuncture needles. I understand that although these treatments are all generally beneficial, safe and natural methods of healing, there are potential risks.

Risks: While acupuncture is a very safe, natural method of treatment, certain side effects may result. Occasionally slight bleeding may occur at point of insertion, although sometimes this is an intentional aspect of treatment. Other possible, although rare, risks from acupuncture may include: Local bruising, Temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days, Dizziness, nausea or fainting that occurs during or after an acupuncture treatment, and Temporary aggravation of symptoms. Extremely rare risks include nerve damage, infection and organ puncture. For heat techniques (fire cupping and moxibustion) there is a slight risk of a minor burn or blister due to heat.
Those taking blood thinners, such as Warfarin, may find they bruise more easily during their treatment. Please advise your practitioner is you are taking any kind of medication.

Pregnancy: Acupuncture and oriental therapies can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. Please notify the acupuncturist should you become pregnant or if you are in the process of trying to get pregnant so that the acupuncturist can make necessary adjustments to your treatment plan.

Privacy: I understand that my information is held in strict confidence and will not be shared with anyone outside of this clinic unless written permission is given by me (or legal guardian).

Cancellation policy: Please understand that your time commitment begins the moment you reserve an acupuncture appointment. When cancellation is necessary, please give advanced notice. Missed or cancelled appointments (medical emergencies excluded) without 24 hour notice will be subject to a fee.

By signing below I show that I have carefully read (or have had read to me) the information on this consent form. I have had the opportunity to discuss any concerns with my Registered Acupuncturist and understand I can request more information at any time. I consent to receive treatment with the above possible procedures with the understanding that I have the right to stop or discontinue treatment at *any time* and that this may affect the expected results. I intend for this consent form to cover the entire course of treatment for my present condition, as well as for any future condition(s) for which I choose to seek treatment.

_____	_____	_____
Print Patient Name	**Signature of Patient (or guardian)**	**Date**

Acupuncturist (initial intake): _____