Best Health Acupuncture & Wellness Clinic
2174 Major Mackenzie Dr. Maple, ON L6A 3Y8
Reception: 905.553.9255
Direct: 647.299.4631

Acupuncture New Patient Intake Form

General Information:

Full Name: _____ Date of Visit (m/d/y):_____

Address:_____ Apt #:_____ City:_____ Postal Code:_____

Home Phone Number:_____ Cell:_____ Email:_____

Date of Birth (m/d/y):_____ Gender: male female Occupation:_____

Emergency Contact:_____ Relation:_____ Telephone:_____

Family Physician:_____ Physician Telephone:_____

Please sign me up for Best Health Acupuncture monthly newsletter YES NO (your information will not be shared)

*It is highly recommended that you sign up for the newsletter as this is a way for us to mass communicate with patients regarding clinic updates, especially during the pandemic when information is constantly changing.

We follow best practices with email marketing in accordance with CASL (Canada's anti-spam Legislation) and you have the option to unsubscribe at any time.

What is your primary reason for seeking care?

Have you had acupuncture before? Yes No If yes, please explain:

Are you currently receiving any other treatment for your condition? Yes No If yes, please explain:

Are you pregnant or is there a chance that you may be pregnant? Yes No

Past or present illnesses (please circle):
AIDS, Asthma, Alcoholism, Allergies, Arthritis, Cancer, Diabetes, Hemophilia, High blood pressure, Heart Disease, Hepatitis, HIV+, Thyroid disease, Surgeries, Significant trauma (car accident, falls, etc.), other: _____

Please list all current medications and supplements you take, including prescription drugs, over the counter drugs, herbs, vitamins, minerals, etc.

Symptoms & Signs (please check all that apply)

Your Lifestyle

☐ Alcohol ☐ Marijuana ☐ Stress ☐ Exercise
☐ Tobacco ☐ Drugs ☐ Occupational Hazards Type: Frequency:

General Symptoms

☐ Poor appetite ☐ Poor sleep ☐ Cold hands or feet ☐ Sweats easily
☐ Heavy appetite ☐ Heavy sleep ☐ Poor circulation ☐ Muscle cramps
☐ Strongly like cold drinks ☐ Dream disturbed sleep ☐ Tingling or numbness ☐ Vertigo
☐ Strongly like hot drinks ☐ Fatigue ☐ Fever ☐ Dizziness
☐ Recent weight gain ☐ Lack of strength ☐ Chills ☐ Bleed or bruise easily
☐ Recent weight loss ☐ Bodily heaviness ☐ Night sweats ☐ Abnormal taste in the mouth (specify):

Head, Eyes, Ears, Nose, Throat

☐ Glasses ☐ Night blindness ☐ Sores on lips or tongue ☐ Sore throat ☐ Migraines
☐ Eye strain ☐ Glaucoma ☐ Dry mouth ☐ Swollen glands ☐ Concussions
☐ Eye pain ☐ Cataracts ☐ Excessive saliva ☐ Lumps in throat ☐ Other:
☐ Red eyes ☐ Teeth problems ☐ Sinus problems ☐ Enlarged thyroid
☐ Itchy eyes ☐ Grinding teeth ☐ Excessive phlegm ☐ Nose bleeds
☐ Spots in eyes ☐ TMJ Colour: ☐ Ringing in ears
☐ Poor vision ☐ Facial pain ☐ Poor hearing
☐ Blurred vision ☐ Gum problems ☐ Earaches ☐ Headaches

Respiratory

☐ Difficulty breathing when lying down ☐ Tight chest ☐ Cough ☐ Coughing blood ☐ Other:
☐ Shortness of breath ☐ Asthma/wheezing ☐ Wet ☐ Dry ☐ Pneumonia
☐ Thick ☐ Thin

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Tachycardia ☐ Irregular heartbeat
☐ Blood clots ☐ Fainting ☐ Difficulty breathing ☐ Heart palpitations ☐ Other:

Gastrointestinal

☐ Nausea ☐ Diarrhea ☐ Intestinal pain or cramping Bowel movements:
☐ Vomiting ☐ Constipation ☐ Itchy anus Frequency: Texture/form:
☐ Acid Regurgitation ☐ Laxative use ☐ Burning anus
☐ Gas ☐ Black stools ☐ Rectal pain
☐ Hiccup ☐ Bloody stools ☐ Hemorrhoid Colour: Odour:
☐ Bloating ☐ Mucous in stools ☐ Anal fissures
☐ Bad breath ☐ Other:

Musculoskeletal

☐ Neck/shoulder pain ☐ Upper back pain ☐ Joint pain ☐ Limited range of motion ☐ Other:
☐ Muscle pain ☐ Low back pain ☐ Rib pain ☐ Limited use:

Skin & hair

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Change in hair/skin texture ☐ Other:
☐ Hives ☐ Psoriasis ☐ Itching ☐ Fungal infections
☐ Ulcerations ☐ Acne ☐ Hair loss

Neuropsychological

☐ Seizures ☐ Poor memory ☐ Irritability ☐ Considered/attempted suicide ☐ Other:
☐ Numbness ☐ Depression ☐ Easily stressed
☐ Tics ☐ Anxiety ☐ Abuse survivor ☐ Seeing a therapist

Genito-urinary

☐ Pain on urination ☐ Blood in urine ☐ STD/STI ☐ Increased libido ☐ Impotence
☐ Frequent urination ☐ Unable to hold urine ☐ Bedwetting ☐ Decreased libido ☐ Premature ejaculation
☐ Urgent urination ☐ Incomplete urination ☐ Wake to urinate ☐ Kidney stone ☐ Nocturnal emission

Gynecology

Age menses began: ☐ Irregular periods ☐ Pregnant ☐ Breast lumps ☐ Fibroids
☐ Painful periods ☐ Possibly Pregnant # Pregnancies: ☐ Endometriosis
Duration of flow: ☐ Clots ☐ Vaginal sores # Live births: ☐ Cysts
☐ PMS ☐ Vaginal discharge # Premature births: ☐ Menopause
Length of cycle: Date of last PAP: Colour: Age at menopause:

Date last period began:

Consent for Treatment

I understand that acupuncture and Traditional Chinese Medicine treatment modalities (such as Tui Na massage/acupressure, moxibustion, Gua Sha, cupping, auricular acupuncture and seeds, electro-acupuncture and heat therapy) are safe and effective for the prevention and treatment of a wide range of health problems, as well are for the promotion of general well-being. I understand that Traditional Chinese Medicine may be helpful to my health condition, but is not intended to replace or substitute any conventional medical treatments, tests, prescriptions, etc. that are recommended by a physician. I am aware that the acupuncturist does not diagnose illness or disease and does not prescribe medication. I acknowledge that the acupuncturist cannot guarantee the results of the proposed treatment.

I have informed the acupuncturist of all my known physical and emotional conditions, medical conditions and medications and I will keep the acupuncturist updated on any changes in my condition. I understand that my full and frank disclosure of my problems and symptoms and honest answers to questions asked are crucial to the acupuncturist's ability to provide me with accurate information and effective treatment. I understand that there shall be no liability on the acupuncturist's part due to my forgetting to relay any pertinent information.

I understand that any medical treatment involves some risks. I consent to receiving treatment and I voluntarily accept the risks involved with acupuncture and traditional Chinese medicine care such as bruising, post needling sensation, fainting, minor bleeding, etc.

I have read this form in its entirety and fully understand this form. I have had the opportunity to ask questions about the content of this form. By signing below I agree to the above named procedures and hereby exempt the acupuncturist from all liability that may occur in connection with the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that I have the right to withdraw my consent at any time.

Treatments at Best Health Acupuncture & Wellness Clinic are performed by Registered Acupuncturists who are members in good standing with The College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO).

_____ _____

Patient's Name (Please print) Date

_____ _____

Patient's Signature Acupuncturist's Signature

Fee Schedule

Acupuncture

Consultation (15 minutes)	Free
Initial assessment + Treatment (1.5 hours)	$125
Follow-up visit (45 minutes)	$75
Re-assessment (1 hour)	$95
Double Session (1.5 hours)	$125
Cosmetic Acupuncture Initial (1.5 hours)	$125
Cosmetic Acupuncture Follow-up (1 hour)	$95

Cancellation Policy

It is my goal to help as many patients as possible. Your appointment time has been reserved specifically for you, so that I can provide you with my full care and attention. If for any reason you are unable to attend your appointment, please allow others the opportunity to take your time slot by providing **24 hour cancellation notice**. Failure to do so will result in a **$75 missed appointment charge**.

I, _____, understand and agree to abide with the cancellation policy.

_____ _____

Patient signature Date

Consent to Collect and Release Information

Amanda Barone, B.Sc, R.Ac, R.Kin
Registered Acupuncturist & Registered Kinesiologist
Best Health Acupuncture Clinic
2174 Major Mackenzie Dr. Vaughan, ON L6A 3Y8
Tel: 647.299.4631 | Fax: 905.553.9155

I, _____, or my appointed representative, _____,
(print name) (print name)

Consent YES NO (please circle)

For clinic Best Health Acupuncture to collect and release my general patient or medical information to other medical or health care providers, emergency personnel and/or and other relevant organizations.
In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In case of emergencies or life threatening situations, medical or support staff workers may have to collect this information from my family members or other listed contacts without your prior written consent.

How Your Information Will be Used

Your personal information can be used or disclosed for the following reasons:

- Referring your medical history to another health care practitioner
- To seek advice for potential treatment options
- To prevent or assist patients in case of emergencies or threat to their health and safety
- To fulfill any obligations mandated by law.
- To direct and guide treatment and program of care

Patient Access to Information

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

Acknowledgment

I allow for medical personnel to use and disclose my information as outlined above.
I understand that I can access my personal health information except as outlined above.
I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional comments or Restrictions:

_____
_____
_____
_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____