



Traditional Chinese Medicine and Acupuncture Intake Form

Rebecca Stephens, Dr.TCM, R.Ac., B.Sc.

To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information provided will be kept confidential in your patient's file.

PATIENT INFORMATION

NAME:		TODAY'S DATE:
DATE OF BIRTH:	AGE:	SEX: M F T
HOME ADDRESS:		POSTAL CODE:
HOME PHONE:	MOBILE PHONE:	
EMAIL:	OCCUPATION:	

EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:
FAMILY PHYSICIAN:	PHONE:	NAME OF CLINIC:
Are you currently under a physician's care? YES NO	If YES, for what?	
List all prescription medications currently taking (with dosage if possible):		
List all non-prescription medications or supplements currently taking:		

REASONS FOR TODAY'S VISIT TO OUR CLINIC

CONCERN	HOW LONG HAS THIS BEEN AN ISSUE?
1.	
2.	
3.	

Please indicate any other current or previous therapies for these concerns:

- Massage Therapy
 Physical Therapy
 Chiropractor
 Medical
 Other _____

How did you hear about the clinic and Dr. Rebecca Stephens?

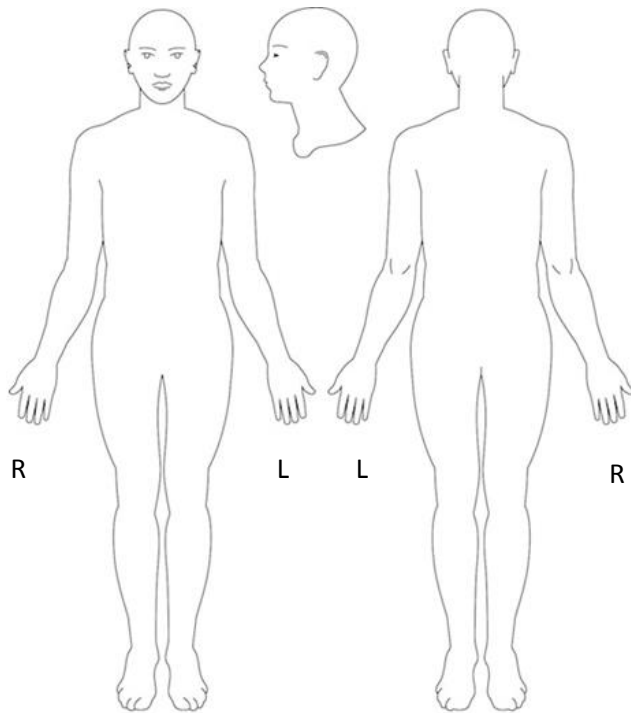
- Internet search
 Walk by
 Family/Friend referral
 Other Health Practitioner Referral

Please provide name and designation of source of referral, if referred by another Health Practitioner:

Is this your first time with Acupuncture or Traditional Chinese Medicine (TCM)? YES NO

If **no**, what have you previously received Acupuncture/TCM treatment for, and when?

On the figures below, please indicate and code your areas of pain/concern:



- P – pins and needles
 - N – numbness
 - S – spasm
 - T – tenderness
 - A – aches
 - R – radiation
 - B – burning
 - X – stabbing
 - O – other (describe)
- _____

GENERAL

HEIGHT:	WEIGHT:
Are you physically active?	How many times do you exercise/week?
Briefly describe your diet, or indicate if you are on a special medical diet:	

PERSONAL MEDICAL HISTORY

Past and current medical diagnosis (given by certified medical professional), include date diagnosed	
List all allergies and sensitivities:	
History of hospitalizations, surgeries, significant illnesses, or injuries (what for, date):	
Are you scheduled for an upcoming surgery? If so, when and for what?	
Do you have a pacemaker?	Do you have any metal implants? (e.g. plate and screws)



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Please check any of the following **conditions** that you currently suffer from, or have a medical history of:

- | | | | |
|--|---|--|---|
| <input type="radio"/> anemia | <input type="radio"/> fibromyalgia | <input type="radio"/> HIV/AIDS | <input type="radio"/> respiratory disease |
| <input type="radio"/> angina | <input type="radio"/> gall stones | <input type="radio"/> kidney disease | <input type="radio"/> gastrointestinal |
| <input type="radio"/> arthritis | <input type="radio"/> glaucoma | <input type="radio"/> kidney stones | <input type="radio"/> skin conditions |
| <input type="radio"/> asthma | <input type="radio"/> irregular pulse | <input type="radio"/> liver disease | <input type="radio"/> spinal injury |
| <input type="radio"/> cancer | <input type="radio"/> heart disease | <input type="radio"/> low blood pressure | <input type="radio"/> fainting episodes |
| <input type="radio"/> chronic fatigue | <input type="radio"/> bleeding disorders | <input type="radio"/> mental illness | <input type="radio"/> stroke / ITA |
| <input type="radio"/> diabetes | <input type="radio"/> hepatitis A | <input type="radio"/> migraines | <input type="radio"/> thyroid problem |
| <input type="radio"/> deep vein thrombosis | <input type="radio"/> hepatitis B | <input type="radio"/> multiple sclerosis | <input type="radio"/> tuberculosis |
| <input type="radio"/> emotional problems | <input type="radio"/> hepatitis C | <input type="radio"/> osteoporosis | <input type="radio"/> ulcers |
| <input type="radio"/> epilepsy | <input type="radio"/> high blood pressure | <input type="radio"/> fractures | <input type="radio"/> varicose veins |

Other (please specify):

Symptom Checklist (please check all that apply):

- | | | |
|--|---|---|
| <input type="radio"/> always feeling cold | <input type="radio"/> dizziness | <input type="radio"/> low immune system |
| <input type="radio"/> always feeling hot | <input type="radio"/> dry mouth/throat | <input type="radio"/> low libido |
| <input type="radio"/> abnormal sweating | <input type="radio"/> dry skin | <input type="radio"/> mouth/tongue sores |
| <input type="radio"/> addictions | <input type="radio"/> easily angered | <input type="radio"/> mucous in stool |
| <input type="radio"/> allergies | <input type="radio"/> edema | <input type="radio"/> muscle tension/spasm |
| <input type="radio"/> anxiety / stress | <input type="radio"/> fatigue | <input type="radio"/> nausea/vomiting |
| <input type="radio"/> apathy | <input type="radio"/> fevers | <input type="radio"/> neck pain |
| <input type="radio"/> asthma | <input type="radio"/> floaters in eyes | <input type="radio"/> night sweats |
| <input type="radio"/> bad breath | <input type="radio"/> foggy thinking | <input type="radio"/> palpitations |
| <input type="radio"/> bad taste in mouth | <input type="radio"/> frequent urination | <input type="radio"/> poor circulation |
| <input type="radio"/> bleeding gums | <input type="radio"/> gas/bloating | <input type="radio"/> poor memory |
| <input type="radio"/> blood in stool | <input type="radio"/> hair loss | <input type="radio"/> post nasal drip |
| <input type="radio"/> blood in urine | <input type="radio"/> headaches/migraines | <input type="radio"/> problems with weight |
| <input type="radio"/> brittle hair/nails | <input type="radio"/> hearing problems | <input type="radio"/> redness in eyes |
| <input type="radio"/> bruise easily | <input type="radio"/> heartburn/acid reflux | <input type="radio"/> restless leg |
| <input type="radio"/> chest pain | <input type="radio"/> heat in palms/soles | <input type="radio"/> ringing in ears |
| <input type="radio"/> chronic cough | <input type="radio"/> hemorrhoids | <input type="radio"/> shortness of breath |
| <input type="radio"/> chronic runny nose | <input type="radio"/> high libido | <input type="radio"/> skin discolorations/moles |
| <input type="radio"/> cloudy urine | <input type="radio"/> infertility | <input type="radio"/> swollen lymph nodes |
| <input type="radio"/> constant thirst | <input type="radio"/> insomnia | <input type="radio"/> tightness in chest |
| <input type="radio"/> constipation | <input type="radio"/> irritability | <input type="radio"/> urinary incontinence |
| <input type="radio"/> depression | <input type="radio"/> loose stools | <input type="radio"/> urinary tract infection |
| <input type="radio"/> diarrhea | <input type="radio"/> low appetite | <input type="radio"/> vision problems |
| <input type="radio"/> difficulty concentrating | <input type="radio"/> low back pain | <input type="radio"/> water retention |

Other (please specify):



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WOMEN'S HEALTH (*marks required fields):

PREGNANCY:

*Is there any chance you are currently pregnant? YES NO (if YES, at _____ weeks)	When is your due date?	Is this your first pregnancy?
Are you carrying twins or multiples?	Is there known breech presentation?	
If pregnant, are there any concerns or complications with this pregnancy?		
If pregnant, are there any symptoms you are experiencing?		

GYNECOLOGY:

*Are you trying to conceive? YES NO	Age when you had your first period	Age when you underwent menopause (if applicable)
Is your period regular?	Length of menstrual cycle (eg "28 days")	*What day of your cycle are you on?
On what day do you ovulate?	Is there any bleeding between periods?	Average length of flow/bleeding (days)
Is your period flow (circle): Very heavy Heavy Average Light Very light	Is the colour of the flow (circle): Brown Purple Dark red Red Light red	Are there clots? YES NO
Do you use birth control? If so, what form?	Do you have any bleeding between periods? YES NO	Do you have any abnormal discharge not associated with your period? YES NO
Have you had any pregnancies? How many?	How many children do you have, and how old are they?	
Have you had problems with pregnancy? Please explain:	Have you had any miscarriages? Please provide dates:	
List any current menstrual symptoms (e.g. PMS, cramps, breast distension, water retention, headaches, nausea, etc)?		
List any current menopausal symptoms (e.g. hot flashes, night sweats, insomnia, etc)?		
Any history of sexually transmitted infections? If so, please indicate what and when:		
Date of last PAP smear, and if any abnormal findings:		
Do you have any other women's health concerns? Please specify:		

MEN'S HEALTH:

Do you have any problems with (please circle): <div style="display: flex; justify-content: space-between; padding: 0 10px;"> <div style="width: 30%;">decreased libido</div> <div style="width: 30%;">ejaculation disorders</div> <div style="width: 30%;">difficulty urinating</div> </div> <div style="display: flex; justify-content: space-between; padding: 0 10px;"> <div style="width: 30%;">infertility</div> <div style="width: 30%;">testicular pain</div> <div style="width: 30%;">urinary incontinence</div> </div> <div style="display: flex; justify-content: space-between; padding: 0 10px;"> <div style="width: 30%;">erectile dysfunction</div> <div style="width: 30%;"></div> <div style="width: 30%;">prostate enlargement</div> </div>
Any history of sexually transmitted infections? If so, please indicate what and when:
Date of last prostate exam, and if any abnormal findings:
Do you have other men's health concerns? Please specify:

Thank you for taking the time to fill out this form thoroughly and to the best of your knowledge. Please note that, for your convenience, if you are seeing more than one practitioner at Healing Cedar Wellness this intake form may be shared.

INFORMED CONSENT - Please read the following information, and ask your practitioner if you have any questions:

The treatments used in the scope of Acupuncture, which include acupuncture, electro-acupuncture, point injection therapy, moxabustion, cupping, gua-sha, and tuina are considered safe and effective treatments. Your practitioner may use one or many of these techniques in the course of your treatment. It is important that you inform your practitioner of all health conditions (including pregnancy and presence of pacemaker) and medications, as some of these techniques could be inappropriate or require modification in these circumstances.

Acupuncture involves the insertion of sterile, single-use, disposable needles to specific points on the body to achieve therapeutic effect. Please be aware that you should not make any significant movements while these needles are being applied, retained, or removed. **Electro-acupuncture** is the addition of a mild electric pulse to these points to increase point stimulation. **Injection Therapy** involves intradermal/intramuscular injection of sterile substances into acupuncture points for therapeutic effect. **Moxabustion** is the application of indirect heat by burning a stick of compressed Mugwort herb over acupuncture points to stimulate meridian circulation. **Cupping** involves the application of round suction cups (glass, plastic, or silicone) over muscle area to enhance blood circulation. **Gua-Sha** is a “scraping technique”, where friction is applied to areas of skin to enhance dermal circulation. **Tuina** is a form of physical manipulation where pressure or massage techniques are applied to points on the body. Please be aware that an infra-red heat lamp is often used during treatment, and treatment tables have heating pads on them, to increase your comfort during treatment.

As with any therapy, there are some risks and possible side-effects to these treatments to be aware of:

Residual needle sensation – there may be a residual sensation at the point of insertion that may last for a period of time after the needles have been removed. Please advise your practitioner if this does not dissipate in 1-2 days

Drowsiness or dizziness - more common if you have low blood sugar or are dehydrated, so please ensure you are fed/hydrated before treatment. Do not drive/operate equipment after treatment if you are feeling dizzy or lightheaded.

Fainting – more likely again if you are hungry or dehydrated, or if it is your first acupuncture treatment (often anxiety-related). Please advise your practitioner if you are feeling faint.

Bruising, bleeding, or swelling – small amounts of bleeding (often 1 or more drops) are common to occur at the site of needle insertion. Bruising may also occur at the needle site. Both cupping and gua-sha commonly leave noticeable marks or bruises on the skin. Bleeding usually ceases within seconds, and bruising usually dissipates within a few days to a week. Please advise a physician if any of these effects seem severe.

Temporary aggravation of symptoms – as with many types of healing, symptoms may sometimes worsen before improving. Please advise your practitioner if symptoms worsen for more than a few days.

Injury (i.e. nerve damage and organ puncture) – considered an unusual risk as practitioners are highly educated in anatomy, and practice extreme caution over areas of the body where delicate structures exist. The risk is thought to be lower for standard acupuncture and slightly higher for injection therapies.

Infection – this is an extremely rare side effect, as aseptic technique is strictly adhered to. Certain medical conditions may increase your risk. The risk is also higher for injection therapies, as outside substance are introduced into the body.

Skin irritation – A common side effect in point injection therapy for scars, due to a detoxification effect. Less common in other injection therapy types. Results in itching and redness, and normally lasts no longer than one day.

Burning – this is possible with moxabustion, and a risk with using an infra-red heat lamp close to the skin. Cupping with glass cups utilizes a small flame to create the vacuum within the cup, so burning is a possibility with this technique as well. Please advise your practitioner or a physician if it seems severe.

The **herbs** used in traditional Chinese medicine (which can be from plant, animal, or mineral source) that have been recommended for use are considered safe. Some of the herbs are inappropriate during pregnancy, or while taking other medications. It is important to inform your practitioner of all these conditions, and keep your practitioner up to date on any changes during the course of your treatment. Possible side effects to herbal therapy include gastrointestinal upset or skin rashes. It is important to cease use immediately, and inform your practitioner, in the case of adverse reaction to herbal therapy. In the rare case of serious anaphylactic reaction, cease use and seek medical attention immediately.

Healing Cedar Wellness is an Integrated Health Clinic, and as such other practitioners working with you have access to your file. This information will only be viewed by the Practitioners you are seeing if and when appropriate. Practitioners also may have a Locum working in their place in circumstances (eg. vacation or illness) when they may be unavailable for your treatment. Every effort will be made to inform you of these circumstances at the time of booking.



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STATEMENT OF CONSENT TO TREATMENT

As a patient of Rebecca Stephens and Healing Cedar Wellness, I hereby request and consent to the performance of treatments on me (or on the patient named below, for whom I am legally responsible) by Rebecca Stephens, and/or other licenced acupuncturists working in her stead. I also confirm that I have the ability to accept or reject this care and treatment of my own free will and choice.

I understand that this form of medical care is based on both Traditional Chinese Medicine principles and practices, as well as on modern methods derived from these principles. I am aware that my treatments may include, but are not limited to, acupuncture, electro-acupuncture, acupuncture injection therapy, cupping, gua sha, moxabustion, Tuina, herbal therapy, and nutritional counselling.

While I do not expect Rebecca Stephens or other clinical staff to be able to anticipate all of the risks and complications associated with my treatment, I wish to rely on them to exercise judgment during the course of my treatment, trusting that, based on the facts then known, this treatment plan is appropriate and in my best interests. I understand that results are not guaranteed. I have been informed that certain side effect reactions to treatment may occur, including such reactions as residual needle sensation, dizziness, fainting, bruising, bleeding, injury, infection, skin irritation, temporary aggravation of symptoms, or other related reactions. I also fully understand that there are possible side effects to herbal therapy, and will cease use and inform my practitioner immediately if these occur.

I understand that these practices are not intended to be substitutes for treatment by a medical doctor. I know that at, at any given time during the treatment, I may request my practitioner to stop, modify, or change the treatment plan. I also know that I may decline treatment by a Locum if I so desire.

As Healing Cedar Wellness is an Integrated Health Clinic; I recognize that all the practitioners that are working with me may have access to my file and will ensure all information is private and confidential. I also recognize that even the gentlest therapies potentially have their complications, and hence the information provided must be complete and inclusive of all health concerns including pregnancy, significant medical history, and all medications (including over the counter drugs and supplements). I will inform my practitioner immediately if there is a possibility that I am pregnant. I understand that it is my responsibility to fully disclose all medications and supplements I may be taking, and refrain from mixing these medications with any prescribed herbal formulas.

I state that I am not an agent of any private, local, provincial, or federal agency attempting to gather information without so stating

I accept full responsibility for fees incurred during this care and treatment, and **agree to the cancellation policy of this clinic requiring 24 hrs notice for all cancelled appointments. With this policy, I am aware that full price of appointment will be charged in the case of missed appointment or late (less than 24 hours) cancellation.** I am also aware that if I show up late for my appointment, that my appointment will still end at the designated time, or that my appointment may be cancelled at my own cost if the Practitioner decides there is not enough time to properly complete a treatment.

Name (please print): _____

Signature: _____ Date: _____

Parental Consent (if under 18): _____

Witness: _____