TCMP INTAKE FORM

Today's Date: _____

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Name (first/last): _____ Middle Initial: _____ Sex: _____

Preferred Name: _____

Date of Birth: _____ Age: _____ Sask Health Card #: _____

Address: _____ City: _____

Prov: _____ Postal Code: _____ Email: _____

Cell #: _____ Home #: _____ Work #: _____

Occupation: _____ Employer:_____

Family Doctor: _____ Parent/Guardian Name (if under 18): _____

Emergency Contact (Name & Phone #): _____

Referred By: _____ Referred To: _____

You can opt to receive emails/texts to keep you informed of new bookings, changes to existing appointments and reminders for upcoming appointments. Please initial the communication you would like to receive:

_____ Emailed notification of new bookings/changes to appointments

_____ Emailed reminders 24 hours prior to appointments

_____ Text reminders 24 hours prior to appointments

_____ Please do not send me any emails/text messages

LATE CANCELLATION/MISSED APPOINTMENT POLICY: As a courtesy to other clients, Chiropractors, and other providers, I understand that I must give at least **24 hours' notice** for cancellations or changes to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments or late cancellations at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, WCB and other insurers do not cover the cost of missed appointments. Please help us serve you better by keeping scheduled appointments. _____ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood, and agree to the above financial policies. _____ (Initial)**

Patient Signature: _____ **Date:** _____

PLEASE CONTINUE ON OTHER SIDE ⟶

MEDICAL INFORMATION:

CHIEF COMPLAINT:_____

When did the problem begin? _____

Medical Diagnosis: _____

What other treatments have you tried?_____

Have you tried Traditional Chinese Medicine before (circle)? Yes / No Acupuncture: _____ Herbs: _____

Occupational stress (chemical, physical, psychological): _____

Are you on a restricted diet or exercise program? _____

Please describe your average diet:_____

How many meals do you eat a day? _____ Do you have any cravings? _____

How many times per week do you use?

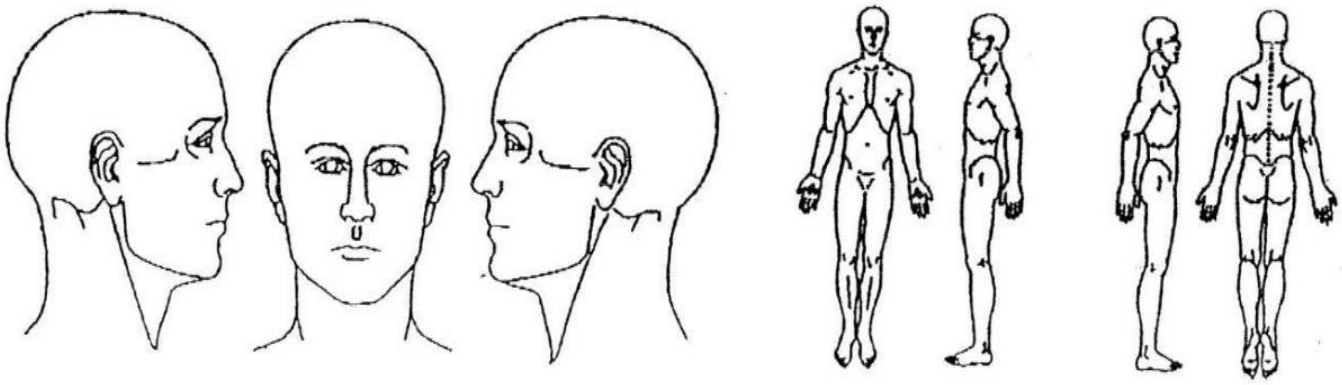
cigarettes_____ alcohol_____ recreational drugs_____ coffee/tea_____ soda_____

Currently on birth control (circle)? Yes / No Are you currently pregnant (circle)? Yes / No Weeks? _____

# of pregnancies: _____ # of children: _____ # of premature births _____ # of Abortions _____

Last pap: _____ Results: _____

Please indicate areas of pain or distress on diagram:



Please list any allergies: _____
_____

Please list any medications: _____
_____

Please list any supplements: _____
_____

HEALTH STATUS SURVEY:

Please **X the box** for any conditions or symptoms **presently causing** you problems.
Please **check (√) the box** for those conditions or symptoms that you **have had in the past**.

Eyes/Ears/Nose/Throat

- ☐ Blurry vision
- ☐ Dizziness
- ☐ Double vision
- ☐ Earache
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Grinding/Clenching teeth
- ☐ Headaches
- ☐ Migraines
- ☐ Ring/buzz in ears
- ☐ Sinus infections

Cardiovascular

- ☐ Angina
- ☐ Bleeding disorder
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ Heart/blood disease
- ☐ High blood pressure
- ☐ Poor circulation
- ☐ Stroke
- ☐ Varicose veins

Gastrointestinal

- ☐ Belching or gas
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Excess hunger
- ☐ Feel heaviness after eating
- ☐ Gall bladder trouble
- ☐ Heartburn
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea/Vomiting
- ☐ Pain over stomach
- ☐ Ulcer

General Symptoms

- ☐ Bleed or bruise easily
- ☐ Catches cold easily
- ☐ Convulsions
- ☐ Excess sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Generalized pain
- ☐ Headache
- ☐ Loss of weight
- ☐ Night pain
- ☐ Night sweats
- ☐ Often feels cold/hot

Genitourinary

- ☐ Bedwetting
- ☐ Blood in urine
- ☐ History of kidney/bladder
- ☐ Impotency
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Pain on urination
- ☐ Prostate trouble
- ☐ Trouble urinating

Gynecological for Women

- ☐ Clots
- ☐ Cramping/backache
- ☐ Endometriosis
- ☐ Excessive flow/heavy
- ☐ Fibroids
- ☐ Hot flashes
- ☐ Infertility
- ☐ Irregular/absent cycle
- ☐ Light period
- ☐ Lump in breasts
- ☐ Painful menstruation
- ☐ PMS
- ☐ Swollen breasts
- ☐ Vaginal discharge

Muscles and Joints

- ☐ Ankle/foot pain
- ☐ Arm/forearm pain
- ☐ Arthritis
- ☐ Elbow pain
- ☐ Hip pain/Painful tailbone
- ☐ Knee pain
- ☐ Loss of strength
- ☐ Low back ache
- ☐ Mid back ache
- ☐ Shoulder pain
- ☐ Sore/stiff neck
- ☐ Wrist/hand pain

Neurologic

- ☐ Clumsiness Fainting
- ☐ Nausea
- ☐ Numbness or tingling
- ☐ Problem speaking
- ☐ Problem swallowing

Skin

- ☐ Boils
- ☐ Bruise easy
- ☐ Dryness
- ☐ Hives (allergies)
- ☐ Rashes/itching

Sleep

- ☐ Deep Sleeper
- ☐ Difficulty falling asleep
- ☐ Easily fall asleep
- ☐ Frequent dreams
- ☐ Light sleeper
- ☐ Nightmares/waking up
- ☐ Not rested upon waking
- ☐ Wake up rested

Patient Signature: _____ Date: _____

INFORMED CONSENT TO TCMP TREATMENT

Patient Information and Consent Form (*Please read this carefully)*

Acupuncture, and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing. Practitioners are required to advise patients that there may be some possible risks and complications that could arise with each individual case.

What are the possible side effects of acupuncture?

Drowsiness can occur in a small number of patients. If affected, you are advised not to drive.
Minor bleeding or bruising can occur from acupuncture and cupping.
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. Fainting can occur in certain patients.

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

The herbs and nutritional supplements that have been recommended are traditionally considered safe.

Is there anything your practitioner needs to know?

If you have ever fainted.
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 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 and future conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visits to Stonebridge Chiropractic is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Stonebridge Chiropractic. Stonebridge Chiropractic 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 client/patient.

Patient Name (please print): _____

Patient Signature: _____ Date Signed: _____

Signature of Parent or Guardian (if under the age of 18): _____