BODY IN BALANCE ACUPUNCTURE

Date (mm/dd/yyyy): _____

HEALTH HISTORY QUESTIONNAIRE

GENERAL INFORMATION

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

Name: _____ /_____ / _____ ___ M ___ F
Last name *First Name* *M. I.*

DOB (*mm/dd/yyyy*): _____ **Age**: _____

Address: _____

City: _____ **Province**: _____ **Postal Code**: _____

Home Phone #: _____ **Cell Phone #:** _____ **Work Phone #:** _____

Email: _____ **Family Physician**: _____

Reason for today's visit: _____

List any medical problems/concerns that other doctors have diagnosed (if available):

_____

_____

_____

How did you hear about acupuncture being offered at this clinic?
(*Check all that apply*)

___ Friend Referral ___ Doctor / Health Practitioner Referral ___ Yellow Pages
___ Internet ___ Lecture / Presentation ___ Calgary Winter Club
Other: _____

PERSONAL HEALTH HISTORY

What forms of treatment / therapy do you currently use?

___ M.D. (name and phone number): _____
___ Physiotherapist ___ Massage Therapist ___ Naturopath ___ Chiropractor
___ Fertility Clinic ___ Other: _____

Have you had acupuncture before? ___Yes ___No

Surgeries:

Month / Year	Reason	Hospital

Other Hospitalizations:

Month / Year	Reason	Hospital

List your prescribed drugs, vitamins, supplements and herbs:

Drug, vitamin, supplement, herb	Strength	Frequency Taken

List any allergies

Allergen	Reaction You Had

P = Past C = Current F = Immediate Family History

Mark which of the following pertain to you with the appropriate letter

___ Heart Condition
___ Stroke
___ High / Low Blood Pressure
___ Diabetes
___ Deep Vein Thrombosis
___ Neurological Condition
___ Spinal or Head Injury
___ Respiratory Disorder
___ Kidney Disorder
___ Cancer
___ Hepatitis
___ HIV/AIDS
___ Sprain / Strain / Fracture
___ Osteoporosis
___ Headaches
___ Jaw Pain
___ Arthritis
___ Dizziness / Fainting
___ Contagious Illness
___ Skin Condition
___ Digestive Problems

Please check off any of the following that apply to you:

Hemophiliac	___Yes ___ No	Epilepsy	___Yes ___No
Wear a pacemaker	___Yes ___ No	Are you a vegetarian	___Yes ___No
Have a serious heart or lung condition	___Yes ___ No	Do you have surgeries scheduled?	___Yes ___No
If you are taking anticoagulant medications	___Yes ___ No	Are you pregnant or is there a chance you may be pregnant	___Yes ___No

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

___ Sedentary (No exercise)
___ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
___ Occasional vigorous exercise (i.e., work or recreation, less than 4 times per week for 30 min)
___ Regular vigorous exercise (i.e., work or recreation 4 times per week for 30 min)

Diet:

Are you on a diet? ___Yes ___No
If yes:
Are you on a physician prescribed diet? ___Yes ___No
Number of meals you eat in an average day? _____
Glasses water per day _____
What is your salt intake? ___High ___ Medium ___Low
What is your fat intake? ___High ___ Medium ___ Low

Caffeine:

___ None ___ Coffee ___ Tea ___ Cola
Number of cups/cans per day? _____

Alcohol:

Do you drink alcohol? ___Yes ___No
If yes:
What kind(s) of alcohol do you drink? _____
How many drinks per week (estimate)? _____

Tobacco:

Do you use tobacco currently? ___Yes ___No ___Occasionally

If yes:

___ Cigarettes - #/day ___ Chew - #/day ___ Pipe - #/day ___ Cigars - #/day

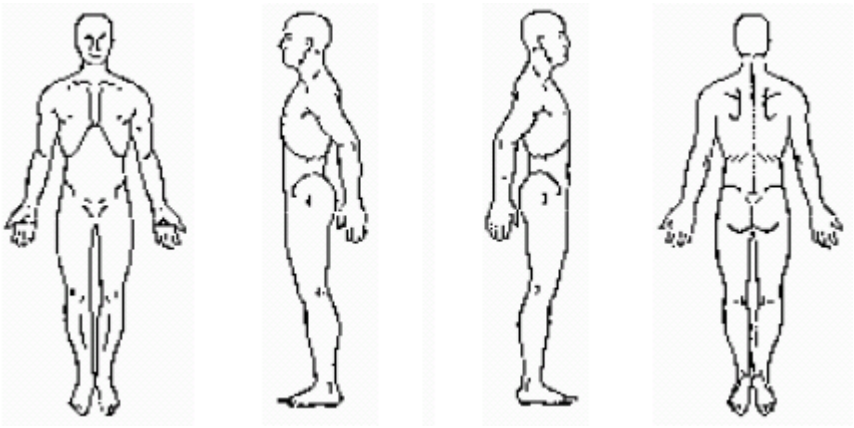
___ # of years

If no:

Have you ever in the past used tobacco? ___Yes ___No ___Occasionally

Approximate year that you quit: _____

On the figures below, please circle the areas of pain / concern:



Sensations / pain: ___ Sharp ___ Burning ___ Moving ___ Shooting
___ Tingling ___ Dull ___ Severe ___ Numbness

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

What aggravates the pain? (Weather, heat, cold, etc.) _____

Other Symptoms/Problems:

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain:

Head & Neck

__ Dizziness __ Fainting __ Neck Stiffness __ Enlarged Lymph Glands
__ Headaches __ Migraines
__ Other _____

Eyes

__ Blurred Vision __ Visual Changes __ Spots/ Floaters __ Eye Pain
__ Dry Eyes __ Poor Night Vision __ Red/burning Itchy Eyes
__ Other _____

Respiratory

__ Chronic Cough __ Coughing up Blood __ Coughing up Phlegm
__ Difficulty Breathing __ Shortness of Breath __ Wheezing / Asthma
__ Frequent Colds
__ Other _____

Genital-Urinary

__ Pain/Itching of Genitalia __ Genital Lesions / Discharge __ Painful Urination
__ Frequent Urination __ Excessive or Scanty Urination __ Blood in Urine
__ Urgent Urination __ Unable to Hold Urine __ Wake up to Urinate
__ Bedwetting __ Increased Libido __ Decreased Libido
__ Kidney Stone
__ Other _____

Cardiovascular

__ Heart palpitations/rapid heartbeat __ Chest pain or tightness __ Poor Circulation
__ Irregular Heart Beat __ Swelling of Ankles
__ Other _____

Nose, Throat & Mouth

__ Bleeding Gums __ Sinus Infection __ Hay Fever or Allergies
__ Recurring Sore throat __ Swollen Glands __ Bitter taste in Mouth
__ Difficulty Swallowing/Lump in throat __ Nosebleeds
__ Tongue/Mouth Ulcers/Canker Sores __ Dry Mouth/Thirst
__ Other _____

Muscles & Joints

__ Joint Pain __ Body Aches/Stiffness __ Weakness __ Difficulty Walking
__ Spinal Curvature __ Numbness/Tingling __ Bodily Heaviness __ Back ache
__ Other _____

Ears

__ Recurring Infection __ Earaches __ Ringing (__ High pitch __ Low pitch)
__ Wax Build up __ Decreased Hearing
__ Other _____

Skin

__ Hives __ Rashes __ Hot Flashes __ Acne
__ Night Sweats __ Dryness __ Eczema/Psoriasis __ Fine Hair/Falling out
__ Bruise Easily __ Itching __ Easily/ Spontaneous Sweating
__ Nails Breaking Easily/Flake Off __ Changes in Moles or Lumps
__ Other _____

Gastrointestinal

__ Nausea __ Vomiting __ Gas __ Rectal Pain
__ Hiccup __ Bloating __ Bad Breath __ Loose/Soft Stools
__ Constipated/Poor Elimination __ Anal Fissures __ Hemorrhoids __ Mucous in Stools
__ Laxative Use __ Black Stools __ Bloody Stools
__ Intestinal Pain or Cramping __ Itchy Anus __ Burning Anus
__ Acid Reflux/Heartburn __ Alternate Loose/Constipation
__ Other _____

Appetite

__ Normal/Healthy __ Exceedingly Hungry __ Poor Appetite
__ Need to Eat Several Meals __ Hungry, But No Desire to Eat
__ Other _____

Sleep

__ Sound/Restful __ Light Sleep __ Insomnia
__ Heavy sleep __ Wake up Easily/Early __ Difficulty Falling Asleep
__ Vivid Dreams/Nightmares __ Dream Disturbed
__ Difficulty Waking Up Number of Hours of Sleep Per Night _____
__ Other _____

Emotions

__ Relaxed / Calm __ Sad/Grief/Depressed __ Fearful __ Impatient
__ Angry / Frustrated __ Forgetful / Poor Memory __ Anxious __ Stressed
__ Other _____

General

__ Cold Hands and Feet __ Cold Nose __ Aversion to Heat or Cold
__ Feel Hot or Cold __ Fever and/or Chills __ Recent Changes in Weight
__ Fatigue
__ Other _____

Other comments:

_____

_____

_____

_____

_____

You have now completed the General health History Questionnaire for Body In Balance Acupuncture. Please make sure to fill out the additional forms specific to your gender. Also please make sure to read the following three contracts thoroughly and bring these and all other intake forms with you to your initial assessment. Thank you very much.

PATIENT INFORMATION & 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 for 1-2 days following treatment. 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;

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

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

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 up on the fact 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.

Privacy Policy

The information received and collected about our clients/patients from their visit to Body In Balance is strictly private and confidential. If is used and viewed only by the healthcare professionals and staff employed by Body In Balance, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Body In Balance (also, Body In Balance 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. The client/patient information will be stored both in digital and hard copy format on Body In Balance premises. On occasion, Body In Balance may use client/patient information to conduct clinical studies to help us improve upon services provided.

_____	_____
Print patient's name in full	Print name of representative, if applicable
_____	_____
Signature of patient	Signature of representative
_____	_____
Date	Date

Appointment Policy

Welcome to Body In Balance Acupuncture. 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 **a treatment room has been reserved for you,** whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling 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. With that in mind, if you are going to be more than 15 minutes late, please call to let us know.

A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid a cancellation fee of $70.00 (the full appointment cost). This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

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

_____	_____
Print patient's name in full	Print name of representative, if applicable
_____	_____
Signature of patient	Signature of representative
_____	_____
Date	Date