RISE Health
1275 Bay Street
Victoria BC V8T 1S8
PH: (250) 381-7473

Acupuncture Intake Form

Name:_____ Sex: ☐Male ☐Female ☐Other

Date of birth (yyyy/mm/dd)_____ Age: _____

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

Please indicate if it is ok to leave a messages at the contact phone numbers above? Yes _____ No_____

Email: _____

**An email reminder will be sent the day before your scheduled appointment.*

Address:_____

City/Province:_____ Postal code: _____

BC Care Card Number: _____

Reasons for seeking treatment? _____

How did you hear about our clinic?_____

Emergency Contact Information Name: _____

Ph: _____ Relationship: _____

☐ Would you like to receive Practitioner Updates, New Services Announcements and Newsletters from RISE Health?
**The anti-spam legislation requires that we ask for your consent to send you emails.*

Office Policy:

☐ In consideration of other patients and my therapist, I understand that a minimum of 24 hours' notice is required to change or cancel my appointment-excluding weekends. I am aware that I am responsible for paying the full treatment fee in the case of late cancellation or missed appointments.

☐ I understand and agree that the cost of treatment is my responsibility, should private insurers (MSP, ICBC, DVA, WCB or other providers) fail to reimburse the clinic for services provided. All outstanding accounts over 60 Days are considered overdue and will be charged at a rate of 25% per annum.

☐ To ensure Rise Health provides the highest level of care to our patients and fulfils the collaborative care model we strive to provide, you agree that all treating practitioners will be permitted access to your Rise Health charts when necessary and provided such access is in accordance with our privacy policy.

☐ I understand that this is a scent free facility.

☐ **Treatment Consent:** I hereby consent to treatments including the use of manual therapy techniques and exercise rehabilitation. I understand there may be some discomfort from the rehabilitation depending on the injury and I agree to inform the therapist should any additional symptoms occur. I understand that all exercise programs place a workload on the body to promote improvement and at the same time present the risk of negative body response to that exercise. I understand that the therapist will do their best care to properly progress, monitor and care for my injuries.

Signature: _____ Date: _____

Health Concerns: Please list the concerns you have about your health today

_____
_____
_____
_____
_____
_____
_____
_____

Conditions: Please check conditions you *currently* have with a ***C*** or have had in the *past* year with a ***P***

□ AIDS
□ Alcoholism
□ Allergies
□ Anemia
□ Anorexia
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Chronic Pain
□ Diabetes
□ Eczema
□ Emphysema
□ Epilepsy
□ Fatigue problem
□ Gallbladder Problem
□ German Measles
□ Glaucoma
□ Goiter
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Intestinal Disorder
□ Kidney Disease
□ Liver Disease
□ Lupus
□ Measles
□ Menstrual Disorder
□ Migraines
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Pacemaker
□ Pneumonia
□ Polio
□ Prostate Problems
□ Psychiatric Care
□ Rheumatic Fever
□ Stroke
□ Stomach Disorder
□ Thyroid Disorder
□ Tuberculosis
□ Ulcers
□ Urinary Tract Infection
□ Vaginal Infection
□ Venereal Disease
□ Other _____
□ Other _____
□ Other _____

Symptoms: Mark symptoms you *currently* have with a ***C*** or have had in the *past* year with a ***P***. Please note the quality of symptoms:

Family History: Check if your blood relations have had any of the following:

□ Arthritis/Gout
□ Asthma
□ Cancer
□ Chemical Dependency
□ Diabetes
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Stroke
□ Tuberculosis
□ Other _____
□ Other _____

Symptoms: Mark symptoms you *currently* have with a ***C*** or have had in the *past* year with a ***P***. Please note the quality of symptoms:

General:
□ Fatigue
□ Insomnia
□ Disturbed sleep
□ Frequent dreams
□ Excessive sleep
□ Dislike cold
□ Dislike heat
□ Weight loss
□ Weight gain
□ Fever
□ Chills
□ Alternating chills and fever
□ Night sweats
□ Unusual daytime sweating
□ Usually thirsty
□ Seldom thirsty
□ Edema or swelling
□ Other: _____

Skin:
□ Rashes
□ Hives
□ Dry Skin
□ Acne
□ Easily bruised
□ Changes in lumps or moles
□ Unusual bleeding
□ Other: _____

Head and Neck:
□ Headaches (note type and location)
□ Dizziness
□ Jaw pain
□ Other: _____

Eyes and Ears:
□ Failing vision
□ Blurred vision
□ Visual spots
□ Night blindness
□ Eye pain/swelling
□ Ringing in the ears
□ Decreased hearing
□ Ear pain
□ Ear discharge
□ Other: _____

Nose/Throat/Mouth:
□ Difficulty in swallowing
□ Change in sense of taste
□ Tooth or gum pain
□ Bleeding gums
□ Mouth or tongue ulcers
□ Other: _____

Muscles and Joints:
Pain, weakness or numbness in:
□ Neck/Shoulder/Arm/Hand
□ Hips/Legs/Feet
□ Sore low back and knees
□ Muscle cramps
□ Body pain
□ Heavy limbs
□ Swollen joints
□ Hot joints

Nervous System:
□ Fainting
□ Paralysis
□ Tremors
□ Poor balance
□ Seizures
□ Other: _____

Heart, Lungs and Chest:
□ Palpitations
□ Chest pain
□ Tightness
□ Rapid heart beat
□ Irregular heart beat
□ Swelling of the ankles
□ Cough
□ Coughing up phlegm
□ Coughing up blood
□ Shortness of breath
□ Asthma/Wheezing
□ Frequent colds
□ Pain in rib cage
□ Other: _____

Mental/Emotional:
□ Difficultly concentrating
□ Poor memory
□ Worry
□ Anxiety
□ Depression
□ Irritability
□ Frustration or anger
□ Fearfulness
□ Stress
□ Other: _____

Digestive System:
□ Nausea
□ Vomiting food
□ Vomiting blood
□ Diarrhea
□ Constipation
□ Loose stools
□ Bloody/black stools
□ Stomach pain
□ Abdominal pain
□ Poor appetite
□ Excessive hunger
□ Abdominal bloating/gas
□ Belching
□ Indigestion
□ Acid reflex
□ Hemorrhoids

Urinary/Genital:
□ Painful urination
□ Difficult urination
□ Frequent day-time urination
□ Frequent night-time urination
□ Incontinence

□ Cloudy urine
□ Bloody urine
□ Genital pain or itch
□ Genital discharge or lesions
□ Painful intercourse
□ Low sexual drive
□ Other: _____

Male:
□ Impotence
□ Weak urinary stream
□ Prostate hypertrophy
□ Premature ejaculation
□ Seminal emissions

Female:
□ Irregular periods
□ Painful periods
□ Bleeding between periods
□ Passing clots
□ Scanty periods
□ Early periods
□ No periods
□ PMS
□ Menopausal symptoms
□ Abnormal PAP smear
□ Breast lump
□ Breast pain or discharge
□ Vaginal discharge
□ Other: _____

Hospitalizations: Please note if you have ever been hospitalized and why.

_____

_____

_____

_____

Medications and Supplements: List any medication or supplements you are currently taking.

Medication/Supplement	Dosage

Allergies: List any medication, food or environmental substances that you are allergic to and the reaction you have.

_____

_____

_____

Health Habit: Check which substances you use and describe how much.

Substance		How much do you use/consume and how often?
Sugar		
Caffeine		
Tobacco		
Alcohol		
Recreational drugs		
Other		

Diet: Describe your diet in general terms. Please include in your description how many meals you eat daily, how often you eat out, if you have any dietary restrictions and what your favourite foods are.

_____

_____

_____

_____

_____

Exercise: Do you exercise regularly?

□ YES

□ NO

If yes, describe the type of activity you do and how often you do it.

_____

_____

_____

Women only: Please answer the following questions if applicable to you.

Menstrual Cycle: Describe your typical period.

_____
_____
_____
_____

How many days are there between your periods? _____
Date of last menstrual period? _____
How many days does your period last? _____

Quality of blood:
□ Light red
□ Bright red
□ Dark red
□ Clotted
□ Other (please describe):

_____
_____

If you are in menopause, please describe the age of onset and the past and current symptoms you experience(d).

_____
_____
_____
_____

Pregnancy and Birthing History:

Are you currently pregnant?
□ YES
□ NO

Are you trying to become pregnant?
□ YES
□ NO

If you use birth control, please note what method you use and how long you have been using this method.

_____
_____

Date of last pap smear: _____

Please note the number of pregnancies you have had, the number of deliveries you have had and any relevant information – i.e. heavy bleeding with delivery, problem free delivery, etc.

_____
_____
_____

Patient Signature: _____

Date Signed: _____ _____ _____
(month) (day) (year)

Patient Information and Consent Form
For ACUPUNCTURE Treatment

"Acupuncture" means the stimulation of a certain point or points near the surface of the body via the insertion of thin needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it also often serves in the treatments of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture or manual stimulation.

The Potential Benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problems.

Potential Risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, numbness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. Very rare risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Every effort of your trained acupuncturist or physiotherapist will be used to avoid this.

Use of Disposable Needles: to reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your physiotherapist or acupuncturist has had training in Clean Needle Technique and Universal Precautions.

DO YOU HAVE:		
Pace maker	YES	NO
Cancer	YES	NO
Artificial implants	YES	NO
Addictions	YES	NO
Allergies	YES	NO

ARE YOU:		
Immunocompromised	YES	NO
Pregnant	YES	NO
Trying to become pregnant	YES	NO
Taking blood thinners	YES	NO

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture 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 for any future condition(s) for which I seek treatment.

Printed Name:_____ Signature_____ Date:_____

Practitioner Name:_____ Signature_____ Date:_____