evolve*
CHIROPRACTIC & WELLNESS CENTRE

TCM and Acupuncture Patient Intake

*denotes R Macdonald Professional Corporation

First Name _____ Last Name _____ Emergency Contact Name and Number _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Home Phone _____

Occupation _____ Email (I agree to receive appointment reminders and clinic updates) _____

Birthdate (dd/mm/yr) _____ Gender _____ Marital Status _____ Alberta Health Care Number _____

Family Doctor _____ Last Physical Exam _____

For your convenience, we can keep a credit card on file:

Card Type: ☐ Visa ☐ Mastercard Number:_____-_____-_____-_____ Expiry:____/____ CCV: _____

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name _____ Group ID/Policy Number _____ Member Number _____

Relationship to Cardholder (self, spouse, child) _____ Name of Cardholder _____

Have you ever had:

☐ AIDS
Hepatitis
☐ A ☐ B ☐ C
☐ Other blood-borne disease_____

Health Priorities/ Chief Concerns:

List your main health concerns in order of importance:

1. _____
2. _____
3. _____

MEDICAL HISTORY

Please indicate any serious illnesses, conditions, or reasons for hospitalization.

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement/Brand	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please indicate any allergies and/or food sensitivities.

Allergy/Food Sensitivity	Symptoms

FAMILY HISTORY

Please indicate whether **you or your immediate family members** have or had the following:

Condition	Who?	Condition	Who?	Condition	Who?
Alchoholism		Cancer Type:		Depression	
Allergies				Osteoporosis	
Alzeimers		Drug Addiction		Parkinsons	
Arthritis Type:		Diabetes Type:		Seizure/Epilepsy	
				Stroke/Aneurysm	
Asthma		Eczema/Psoriasis		Thyroid Condition Type:	
Autoimmune Disease Type:		Heart Disease			
		Kidney Disease		Tuberculosis	
HIV/AIDS		Liver Disease		Other	

LIFESTYLE

Living Environment: ☐ Dry ☐ Damp

Favorite Food and Drink Type: ☐ Sour ☐ Sweet ☐ Salty ☐ Greasy ☐ Spicy

Do you use any of the following? ☐ Cigarettes ☐ Alcohol ☐ Recreational Drugs

Glasses of water per day? _____

Cups/ glasses per day? Coffee ____ Cold Drinks ____ Warm Drinks ____

Do you exercise? ☐ Yes ☐ No What type, how often? _____

Are you frequently in a state of: ☐ fear ☐ worry ☐ anger ☐ sadness ☐ anxiety?

Rate your stress level: (low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high)

Which factors most contribute to your stress? ☐ Health ☐ Work ☐ Money ☐ Family ☐ Marriage ☐ Relationship ☐ Other

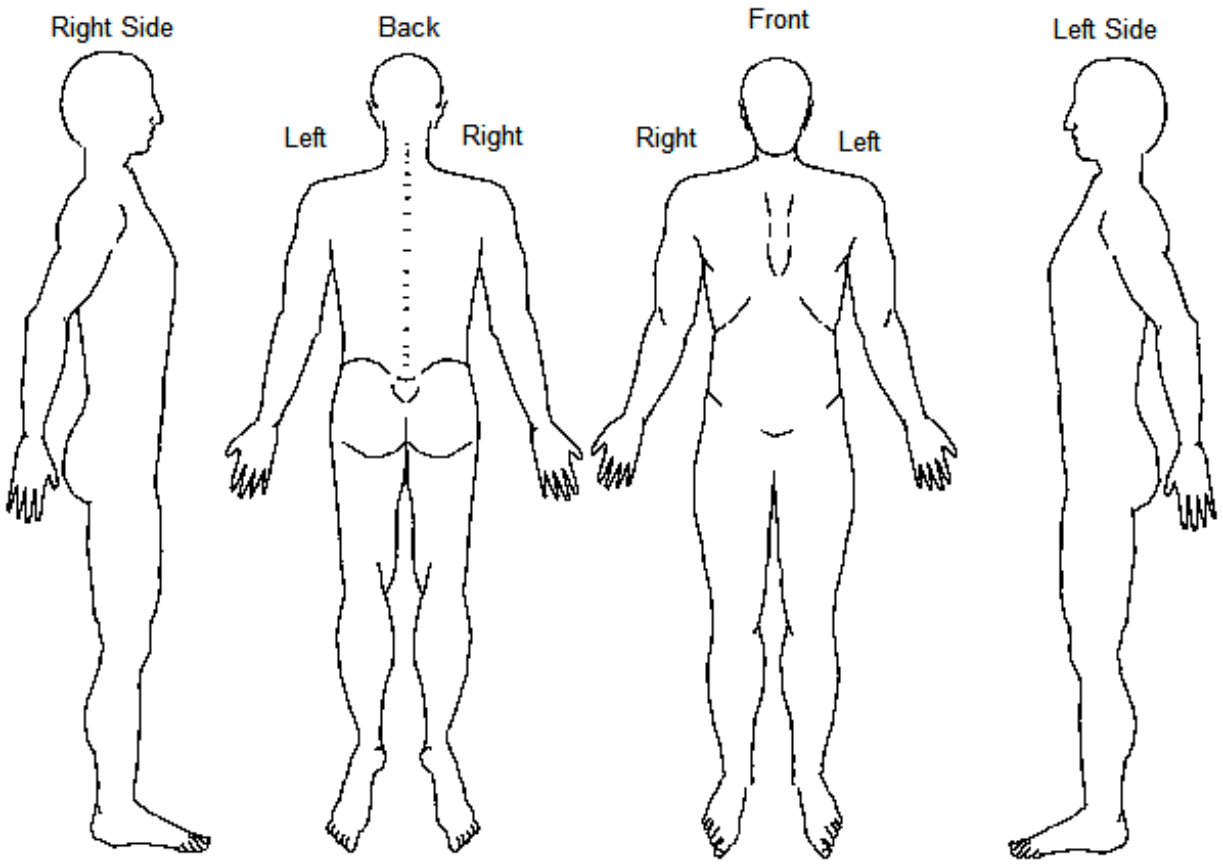
_____

Is there anything that you feel is important that has not been covered?

_____

_____

Indicate the location of your pain by shading the appropriate area:



Informed Consent for Traditional Chinese Medicine and Acupuncture Care

Dr. Amanda Perizzolo TCMD, R.Ac

Dr. Eric Stretch DTCM, R.Ac

PLEASE READ AND INITIAL EACH SECTION BEFORE SIGNING BELOW.

Traditional Chinese Medicine

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications. It is important that you inform your practitioner immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding.

There are some health risks associated with treatment by Traditional Chinese Medicine. These include but are not limited to:

- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Practitioner of any allergies you may have.
- Muscle strains and sprains, and disc injuries from spinal manipulation.
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand that my TCM practitioner will answer any questions that I have to the best of his/her ability. I understand that results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and complications. I will rely on the practitioner to exercise judgment during the course of my treatment which s/he feels is in my best interest based on the facts which are known**.**

With this knowledge I voluntarily consent to the treatment recommended to me by my practitioner. I intend for this consent to apply to all my present and future Traditional Chinese medicine Care.

_____
INITIALS

Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above named doctor or another duly authorized doctor in the clinic.
I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.
I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.
I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests.
I understand that the results are not guaranteed.
I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below i agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of the treatment for my present and future conditions for which I seek treatment.

_____
N.B. Female Patients: **INITIALS**
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

Credit Card Holder Authorization

I, the previously-named authorized credit card user, give Evolve Chiropractic and Wellness Center express authorization to charge my credit card for the purposes of 1) Payment for services rendered by any practitioner at Evolve Chiropractic and Wellness Center. 2) Payment for goods purchased from any practitioner at Evolve Chiropractic and Wellness Center. 3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges as well as any and all collection and legal fees. This credit card is authorized for only the charges noted above.

_____
INITIALS

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

Dated this_____ day of_____, 20_____.

_____ _____
Patient Signature (or Legal Guardian) Witness of Signature