NEW PATIENT FORMS

First name:	Second name:	DOB	Age	

Address: **County:**

E-mail

Phone #: (H) (W) (C)

Can we leave a message, if you are not available? ❑ Yes ❑ No

Occupation:

Can we call you at work? ❑ Yes ❑ No

Preferred Method of Communication: ❑ Phone Call ❑ Text Message ❑ Email

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

EMERGENCY CONTACT: Name: **Relationship:** **Phone #:**

GP Contact Details:

How did you hear about us? ❑ Community Impact ❑ Drive-by ❑ Dinner Talk ❑ Postcard mailing ❑ Neighbourhood Newsletter

❑ internet search: _____ ❑ Referral/Other: _____

HEALTH HISTORY

MAIN COMPLAINTS	Intensity	
If you could get rid of any health problems what would you want to get rid of. (please list in the order of importance below), and we will let you know if we can help.	On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = ***no discomfort***,10 = ***extreme discomfort***)	
	on **AVERAGE** your complaint is	at **WORST** your complaint is:
1.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

6.		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Onset		What have you tried doing to resolve these problems that DID NOT work?
For each condition listed above, please mark when it first began, or when you started experiencing them?		The definition of "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or he treatment did not restore your body's own ability heal itself.
1	Date began:	
2	Date began:	
3	Date began:	
4	Date began:	
5	Date began:	
6	Date began:	

Frequency		Duration
Please check the box that best represents how frequent you feel your chief complaint(s):		when you are feeling your symptoms, how long do your symptoms last?
1	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
2	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
3	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
4	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
5	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
6	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant

What Aggravates or Alleviates your Chief Complaints?

	What AGGRAVATES each of the complaints above?	What ALLEVIATES each of the complaints above?
1		
2		
3		
4		
5		
6		

How are your health problems interfering with the following areas of your life?

Work	
Family	
Hobbies	
Life	

How have you taken care of your health in the past?

Medications	Dietary Modifications	Chiropractic
Surgery	Vitamins & Supplements	Arrosti / Active Release Therapy
Injections	Acupuncture	Massage
Exercise	Chinese Herbal Medicine	Other: _____

How did the previous methods work for you? _____

_____

ARE YOU HERE VISITING US, BECAUSE YOU: (please choose one)

a) Just want to get some Relief from your symptoms, and then you'll manage the rest with medication

b) Want to Find & Correct the Root Cause of your Health problem(s), if possible, and Start a Lifestyle program for optimized living where your body can heal itself without medications or be less dependent upon medications.

c) Other: _____

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? *(Please take your time and don't sell yourself short!)*

_____

_____

_____

ARE YOU PREGNANT? : ❑Yes ❑No ❑If yes, how far along? _____

Do you exercise: ❑Never ❑Daily ❑Weekly ❑Monthly Explain:_____

_____

Do your work activities mostly involve: ❑ Sitting (time:) ❑ Standing (time:) ❑ Light Labour ❑ Heavy Labour

What is your daily/weekly intake of the following: Caffeine _____ Alcohol _____ Nicotine/Tobacco _____

Illicit Drugs: ❑Yes ❑No Comments _____

IMAGING & TESTS	DATE (S)	RESULTS *(list area that was imaged)*
X-ray (s)		
MRI (s)		
CT (CAT) Scan (s)		
Ultrasound (s)		
Cholesterol		
Blood Sugar		
Mammogram		

PAP Smear		
Blood Tests (which?)		
Nerve Conduction		

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anaemia
- ❑ Anorexia
- ❑ Autoimmune Disorder
- ❑ Bladder Diseases (UTI, IC)
- ❑ Bleeding Disorders
- ❑ Blood pressure (too high / too low)
- ❑ Bulimia
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes (Type 1 / 2)
- ❑ Epilepsy
- ❑ Gall Bladder Disease
- ❑ Goiter
- ❑ Gonorrhoea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Infertility
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Sugar
- ❑ Lung Disease (bronchitis, pneumonia, emphysema)
- ❑ Measles
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Neuropathy
- ❑ Pacemaker, Defibrillator
- ❑ Paralysis / Semi paralysis
- ❑ Parkinson's Disease
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Scarlet Fever
- ❑ Skin Disorders (rash, eczema, psoriasis)
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Disease (hyperthyroid, hypothyroid)
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Whooping Cough

Please list ALL health care providers (family physicians, surgeons, specialists, chiropractors, etc.) currently treating you:

_____

_____

List ALL disorders you are CURRENTLY being treated for (include the dates of when you were diagnosed):

_____

_____

List ALL types of Surgeries you have had in the past (Include Dates):

_____

_____

List ALL Accidents and/or Hospitalizations you have had in the past (Include Dates):

_____

_____

List ALL Allergies (Food, Medications, Pollen, etc):

_____

List ALL Medications (prescription & over-the-counter) you are CURRENTLY taking (include duration of use & Dosage):

_____

_____

List ALL Nutritional Supplements, Herbs, or vitamins you are currently taking:

_____

_____

LIST ALL MEDICAL CONDITIONS OF YOUR IMMEDIATE FAMILY:

	MOTHER	FATHER	BROTHERS	SISTERS
age if living				
if deceased, cause of death				
Cancer (s)				
Diabetes				
Heart Disease				
Stroke				
Autoimmune Disorders				
Mental Illness				
Other				

We find that when all of your healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here?

❑ yes ❑ no

IMPORTANT: Complete these documents as thoroughly as possible, please be honest with yourself. Some of the questions that follow may seem unrelated to your condition, BUT they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

Please check all symptoms that you experience either ACUTELY or CHRONICALLY

LUNG System Function *(Large Intestine, Thyroid, Thymus)*	**SPLEEN System Function** *(Stomach, Pancreas)*
❑ Shortness of Breath	❑ Low appetite
❑ Wheezing / Difficulty Breathing / Heaviness in chest / Asthma	❑ fatigue after eating
❑ Easily catch colds / Chronic Infections	❑ Loose stools / Diarrhoea
❑ Nasal / Sinus Problems	❑ undigested food in stool
❑ Nose Bleeds	❑ Abrupt Weight Gain
❑ Cough (dry / productive / blood / persistent)	❑ Abrupt Weight Loss
❑ Snoring	❑ Abdominal Bloating / Gas
❑ Loss of Smell / Taste	❑ Gurgling noise in stomach
❑ Dry Nose / Mouth	❑ Bleeding, swollen/painful gums
❑ Dry / Sore Throat	❑ Heartburn / Acid Regurgitation
❑ Dry Skin	❑ Nausea / Vomiting
❑ Allergies, Sneezing	❑ Frequent Belching / hiccups
❑ Alternating fever & chills	❑ Frequent / Constant Hunger
❑ Excessive Sweating	❑ Stomach pain
❑ Difficult Sweating	❑ Bad breath
❑ Headaches	❑ Canker sores in the mouth
❑ Stiff Neck & Shoulders	❑ Bruise easily
❑ Chronic sadness	❑ Always worrying / over-thinking everything
❑ Constipation / Difficult Defecation	❑ Weak / Atrophy in muscles
❑ haemorrhoids / Blood / Mucous in Stools	❑ whole body feels heavy
	❑ Fluid retention (oedema, heavy limbs & body)
	❑ Swollen feet / Legs / Joints

HEART System Function *(Pituitary Gland, Small Intestine)*

❑ Anxiety / Restlessness	❑ Frequent Dreams	❑ Fast heart beat (>100 beats/min)
❑ Sores on tip of Tongue, speech problems	❑ Mental Sluggishness / Fogginess	❑ Slow heart beat (<50 beats/min)
❑ Trouble falling / Staying asleep	❑ Inability to focus (ADD, ADHD)	❑ Irregular heart beat
❑ waking up unrefreshed, tired	❑ Chest Pain traveling to shoulder	❑ Palpitations / Heart Fluttering

LIVER System Function *(Gall Bladder, Pineal Gland)*	**KIDNEY System Function** *(Urinary Bladder, Adrenal Glands)*
❑ Alternating Diarrhoea & Constipation ❑ Tight sensation in the chest ❑ Bitter taste in the mouth ❑ Irritable, Angry & frustrated frequently ❑ Mood Swings ❑ suffer from depression ❑ Skin Rashes (redness, itching) ❑ Headache at the top & sides of the Head, Migraines ❑ Numbness / Tingling Sensation ❑ Muscle Twitching / Cramping / Spasms ❑ Seizures / Convulsions, tremors, tics ❑ Lump in the throat ❑ Neck & Shoulder Tension / tightness / pain ❑ Joint Pain ❑ TMJ pain ❑ High-pitched ringing in ears ❑ Difficulty adapting to stress, teeth grinding ❑ Dizziness / poor balance / vertigo **EYES/VISION** ❑ Itchy Eyes ❑ Blood Shot Eyes ❑ Burning Eyes ❑ Dry Eyes ❑ Watery Eyes ❑ Gritty Eyes ❑ Blurry Vision ❑ Decreased Night Vision ❑ Floaters in the eyes	❑ Cold Hands & Feet ❑ Feels cold all the time whole body ❑ Hot Flashes & Night Sweats ❑ Thirsty all the time ❑ Frequent cavities, teeth problems ❑ Sore Achy / Weak Knees ❑ Lower Back Pain ❑ Memory Problems (short term & long term) ❑ Excessive hair loss, premature greying of hair ❑ Low-pitched ringing in the ears ❑ Poor Hearing / Hearing problems **URINATION** ❑ Lack of bladder control (incontinence) ❑ Wake during the night >1 time to urinate? ❑ Scanty Urination ❑ Profuse Urination ❑ Frequent Urination ❑ Urgency to urinate ❑ Difficult / Incomplete urination ❑ Painful / Burning urination ❑ Cloudy Urine ❑ Reddish urine ❑ history of chronic fear ❑ Easily startled ❑ General Weakness, low energy, chronic fatigue ❑ Low or No Libido ❑ Excessively high libido **FOR MEN ONLY** ❑ swollen testes ❑ Testicular Pain ❑ Inability to maintain erection ❑ Premature ejaculation

Patient Name: **DOB:** **Date:**

INFORMED CONSENT TO CARE

A patient coming to the Acupuncturist or doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The Acupuncturist or doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescr bed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I understand that methods of treatment may include, but are not limited to, acupuncture, mox bustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counselling, and physical medicine services. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are 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. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhoea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

With any of the following issues, please consult your physician first before using any vibration machine. If you are recovering from surgery, have serious cardiovascular disease, are pregnant. You have thrombosis, joint implants, a pulmonary embolism, known retinal conditions, severe diabetes, a pacemaker, an implantable cardioverter defibrillators, hip or knee replacement, epilepsy, tumours, acute hernia recently replaced pins or plates, poor somatosensory receptor sensitivity on the plantar surfaces of the feet, or have a severe migraine. Because the VibePlate is much different than other vibration machines, we have had customers use the VibePlate for some of the above issues with no negative feedback. But we still ask you to consult your physician before using the VibePlate.

While I do not expect the clinical staff to be able to anticipate and explain all poss ble risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I hereby authorize Malik Khan dba Achieve Health to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim.

Prior to receiving care a health history and physical examination will be completed. These procedures will assist the practitioner in determining which modalities are needed, or if any further examinations or studies are required. 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.

I have read and understand the above consent form.

Patient's Signature: _____ Date: _____
Parent or Legal Guardian (if under 18) printed name: _____
Parent or Legal Guardian Signature: _____