healthflow
integrative health centre

Suite 117, 1330 15th Avenue SW,
Calgary, Alberta
403.313.4354 ♦ info@healthflow.ca

Traditional Chinese Medicine (TCM) Patient Intake Form

CONTACT INFORMATION:

Name: ______________________________ Age: _______ Date of Birth: _________ Gender: ☐ M ☐ F

Address: ____ Email: _____________________________

Would you like to be kept up to date with Healthflow promotions, announcements, seminars, upcoming community events, etc via e-mail? ☐ Yes ☐ No

Phone H: ________________________ W: ________________________ C: ___________________________

Occupation: ______________________________________ Country of Origin:__________________________

Emergency contact: ____________________ Relationship: ________________ Phone: __________________

Medical doctor: ____ Phone: __________________

How did you hear about us?

☐ Friend or Family Member (If so, please indicate name: _________________________________)
☐ Outside Therapist (If so, please indicate name/clinic:___________________________________)
☐ Healthflow Therapist ☐ The Yoga Studio ☐ Signage
☐ Internet ☐ Seminar / Event

HEALTH GOALS/CONCERNS

What is your main health goal/concern?

____

____

How long ago did this problem begin?

____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition:

____

Previous practitioners consulted for this condition: ☐ MD ☐ ND ☐ Other___________________________

Please explain their diagnosis, therapy and results where applicable:___________________________________

____

What kinds of treatment have you tried for this problem?

☐ Diet modification ☐ Vitamin/mineral supplements ☐ Herbs ☐ Homeopathy

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☐ Chiropractor ☐ Acupuncture ☐ Conventional drugs ☐ Other ________________

What makes it better? _________________________What makes it worse? ____________________________

To what extent does this problem interfere with your daily activities?

____

____

Please list any other health concerns or goals in order of importance: __________________________________

____

____

____

MEDICAL HISTORY:

How would you describe your general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate with a P (past) or C (current) if you have been affected by any of the below conditions:

	Alcohol/Drug Abuse		Glaucoma		Kidney Disease		Skin disease
	Arthritis		Headaches		Low Blood Pressure		Sprain/ Strain/Fracture
	Asthma		Heart Disease		Low Blood Sugar		Stroke
	Blood Disorder		Hepatitis		Liver Disease		STI (VD, etc.)
	Cancer		High Cholesterol		Mental Illness		Thyroid Disorder
	Diabetes		HIV/ AIDS		Migraines		Tuberculosis
	Digestive Disorder		High Blood Pressure		Osteoporosis		Upcoming Surgeries
	Epilepsy/ Seizures		Jaundice		Respiratory Condition		Vein Condition
	Fainting/ Dizziness		Joint replacements		Other:		

For the following tables, please use the back of this page if more room is required:

Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization, Surgery, Injury	Date	Symptoms	Condition Resolved?

Allergies/ food sensitivities/ and food intolerances:

Allergy/Sensitivity	Symptoms	Treatment/Avoidance?

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Current medications/supplements - list ALL medications or supplements you take on a regular basis:

Medication/Supplement	Dosage	Length of Use	Prescribed by?	Taking Presently?

Please list if applicable any childhood illnesses

____

____

FAMILY HISTORY:

Mother____

Father ____

Grandparents____

Siblings____

Children____

DIET & DIGESTION:

How is your appetite?

☐ Normal ☐ Under-eat ☐ Overeat ☐ Easily Hungry ☐ Hungry, but no desire to eat

How many meals do you eat per day? _______ When do you usually eat? ___________________________

Do you ever have indigestion after eating or stomach pain, discomfort, nausea, vomiting? If so, please describe:____

____

Do you eat dairy? ☐ Y ☐ N Do you eat meat? ☐ Y ☐ N

Do you crave flavors? ☐ Sweet ☐ Salty ☐ Sour ☐ Bitter ☐ Spicy

Have you ever received antibiotics for an extended period? ☐ Y ☐ N If yes, how often?______

____

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How much liquid do you drink per day?

Glasses of water daily: ______ Soft drinks daily: _____ Cups of tea daily: _____ Cups of coffee daily: ______

Alcoholic beverages per day/ week: ________ Preference for hot or cold drinks? ________________________

How are your bowel movements?

Do you have:

☐ Diarrhea ☐ Dry Stools ☐ Alternating Diarrhea/Constipation

☐ Constipation ☐ Loose Stools ☐ Straining

How many bowel movements do you have per day? __________ When? _____________________________

Do you have: ☐ Gas ☐ Bloating ☐ Bad Breath

Describe your typical daily diet:

Breakfast:____

Lunch:____

Dinner: ____

Snacks: ____

Special Diet:_________________________ The 3 worse foods you eat: ________________________________

URINATION:

How often do you urinate in a day? __________ When? ____

Do you have: ☐ Profuse Urine ☐ Scanty Urine ☐ Interrupted Flow

Is it difficult to urinate? ☐ Y ☐ N Painful? ☐ Y ☐ N

If so, please describe:

____

____

What colour is the urine? ☐ Clear ☐ Light Yellow ☐ Dark Yellow

Do you wake up in the night to urinate? ☐ Y ☐ N If so, how often? __________________________

ENERGY:

Do you feel that you have enough energy during the day? ☐ Y ☐ N Energy Level (1-10): ____

When do you have the most energy? ______________________ The least energy? ______________________

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Does physical activity increase your energy level, or deplete it? ☐ Increase ☐ Deplete

Describe: ____

____

Do you exercise? ☐ Y ☐ N If yes, how often? ________________ Describe:

____

What else do you do to support your health? ____

____

What do you do that may negatively impact your health?_________________________________

____

Smoke: ☐ Y ☐ N Drink: ☐ Y ☐ N Recreational Drugs: ☐ Y ☐ N

SLEEP:

What time do you go to bed? ________________ How easy is it for you to fall asleep? ________________

Do you wake up in the night? ☐ Y ☐ N If yes, what wakes you? ______________________________

Do you dream? ☐ Y ☐ N What time do you wake up?

____

Do you feel rested in the morning? ☐ Y ☐ N Do you nap during the day? ☐ Y ☐ N

SKIN/SWEAT:

Do you experience any of the following?

☐ Sweat easily	☐ Sweaty hands and feet	☐ Acne or Boils
☐ Profuse sweat	☐ Dry skin	☐ Bruise easily
☐ Sweat at night	☐ Rashes	☐ Eczema

Does your sweat have an odour? ☐ Y ☐ N If so, describe:

____

TEMPERATURE:

Do you tend to feel more hot, or more cold? ____

Do you experience any of the following?

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☐ Cold hands ☐ Cold feet ☐ Other areas cold:________________

☐ Hot hands ☐ Hot feet ☐ Other areas hot: ________________

☐ Fever ☐ Chills ☐ Alternating fever and chills

☐ Aversion to cold ☐ Aversion to heat

EMOTIONAL WELLNESS

Do you frequently experience any of these emotions?

☐ Anxiety/Fear ☐ Worry/Overthinking ☐ Anger/Irritability ☐ Mood Swings

☐ Sadness/Grief/Depression

Have you been treated for emotional issues? ☐ Y ☐ N

Do you have any other neurological or psychological concerns? ☐ Y ☐ N If yes, explain:

____

If you were to describe yourself from an emotional standpoint what would you say? (e.g. irritable, stressed, a worrier ____

Is there a history of addiction/abuse? ____

Do you enjoy your work? ____

What is the major source of joy in your life? ____

____

What is the major source of stress in your life? ____

____

PAIN/TENSION

Please describe any pain or tension you are currently expriencing:

Location	Intensity 1=mild, 10=severe	Nature (sharp, stabbing, dull, aching, numbness, pins and needles)

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FOR WOMEN

Age of first period: ___________ Number of pregnancies: ____________ Number of children: ____________

Is your menstrual cycle regular: ☐ Y ☐ N Average days of entire cycle: ___________________________

How many days does your period last? ______________ Is the flow: ☐ Heavy ☐ Light ☐ Normal

What colour is the flow? ☐ Bright Red ☐ Pale Red ☐ Dark Red ☐ Purple ☐ Brown

Are there clots? ☐ Y ☐ N What colour are they? ____________ What size are the clots? ________

Which of the following pre-menstrual symptoms do you experience?

	Breast distension		Water retention		Nausea		Constipation
	Breast tenderness		Headaches		Vomiting		Alternating diarrhea/constipation
	Food cravings		Migraines		Diarrhea		STI (VD, etc.)
	Irritability		Anxiety		Other emotions:		
	Abdominal cramps:(If so, describe where you feel the pain)						

Please describe the nature of cramping:

	Stabbing		Better with pressure		Better with heat		Better with exercise
	Aching		Worse with pressure		Better with cold		Worse with exercise

Do you have vaginal discharge? ☐ Y ☐ N Describe colour, viscosity and odor of discharge:
____

Do you experience:

	Vaginal dryness		Vaginal irritation		Bleeding between periods
	Vaginal pain		Vaginal itch		

Age of last period: ____________ Please describe any menopausal symptoms: __________________________
____

Are you pregnant: ☐ Y ☐ N Do you plan to become pregnant? ☐ Y ☐ N

FOR MEN:

Do you experience:

	Swollen testes		Impotence		Feeling of coldness or numbness in genitals?
	Testicular pain		Premature ejaculation		Other:

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For every symptom you are currently experiencing below, please rate from 1 to 5 (5 being the worse)

Liver
___Irritability/frustration/impatient
___Stress
___Emotional eating
___Unfulfilled desires
___Visual problems/ floaters
___Blurred vision/ poor night vision
___Red/ Dry/ Itchy eyes
___Headaches/ Migraines
___Dizziness
___Feeling lump in throat
___Muscle twitching/ spasm
___Neck / shoulder tension
___Brittle nails
___Sighing
___Sensation or pain under rib cage
___PMS
___Genital itching/ pain/ rashes

Heart
___Palpitations
___Chest pain/ tightness
___Insomnia/ Sleep problems
___Restless/ easily agitated
___Vivid dreams
___Lack of joy in life
___Forgetful
___Aversion to heat
___Bitter taste in mouth
___Tongue/ mouth ulcers/ cankers

Kidney
___Frequent urination
___Bladder infection
___Lack of bladder control
___Wake to urinate
___Feel cold easily
___Cold hands/ feet
___Night sweats/ hot flushing
___Low sex drive
___High sex drive
___Loss of head hair
___Hearing problems
___Crave salty food
___Fear
___Poor long term memory
___Ankle swelling
___Tinnitus (ringing in ears)
___Popping in the ear

Lung
___Dry cough
___Cough with Phlegm
___Nasal discharge/ drip
___Sinus infection/ congestion
___Itchy/ painful throat
___Dry mouth/ throat/ nose
___Skin rashes/ hives
___Snoring
___Shortness of breath
___Allergies/ asthma
___Weak immune system
___ Smoke
___Alternate fever/ chills

Spleen
___Heaviness in the head/ body
___Fatigue/ after eating
___Difficult getting up in morning
___Water retention
___Muscular tired/ weak
___Bruise easily
___Unusual bleeding (stool, nose, etc.)
___Bad breath
___Poor appetite
___Increased appetite
___Crave sweets
___Poor digestion
___Nausea/ vomiting
___Bloating/ gas
___Hemorrhoids
___Constipation
___Loose stool
___Alternate constipation/ loose
___Abdominal pain
___Intestinal pain/ cramping
___Heartburn
___Pensive/ over-thinking
___Overweight
___Foggy mind
___Yeast infection
___Aversion to cold
___Cold nose
___Increased thirst
___Prefer warm/ cold drinks
___Sweat easily

OTHER

Is there anything else that you feel is important that hasn't been addressed by this form? __________________

____

____

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PATIENT CONSENT FORM FOR ACUPUNCTURE AND TRADITIONAL CHINESE MEDICAL TREATMENT

I, _____________________________(print name), hereby fully understand the acupuncture treatment process and the possible side effects such as: fainting, small bruises, post-acupuncture sensations (numbness, tingling, heaviness, and fatigue), temporary exacerbation of symptoms, changes in sleep, appetite, bowel or urination patterns, or emotional state.

I agree to fully disclose all past and current health conditions. I also give consent to have acupuncture and all treatments included in Traditional Chinese Medicine such as: Chinese herbs, Tui Na massage, cupping, moxibustion, TDP lamp, electric stimulation, and auricular therapy from Dr. Laurel Stuart.

Complementary to the treatments of TCM, you may also consult other health practitioners such as: Massage Therapists, Chiropractors, Physiotherapists, Nutritionists, or Naturopathic Doctors.

Alberta acupuncture legislation states that an acupuncturist must not treat someone who has not consulted with a primary care physician, or, in the case of dental pathology, a dentist about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable bracket confirming that you have already seen a physician, or will be seeing one within two weeks of your first acupuncture treatment.

{ } I have already seen a primary care physician (Western Medical Doctor) regarding the condition(s) that I am seeking treatment for.

{ } I agree to see a doctor regarding the condition(s) that I am seeking treatment for within two weeks of my first acupuncture treatment at Healthflow Integrative Health Centre.

___________________________ ___________________________

Patient Signature **Date**

___________________________ ___________________________

Witness Signature **Date**

___________________________ ___________________________

Parent/Guardian Signature **Date**

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WHAT TO EXPECT DURING YOUR FIRST VISIT WITH THE TCM DOCTOR

You may print all of the forms and fill them out, or you may come 15-20 minutes before the appointment to fill out the forms at the health centre.

Before your treatment, please make sure that you:

- are neither hungry or full. It is best to have a small meal or snack an hour before your treatment.
- are not under the influence of alcohol or other drugs.
- are hydrated.
- wait at least ½ hour after moderate or intense physical activity.
- inform Dr. Stuart if you are feeling any strong emotions or anxiety the day of your appointment.
- do not brush your tongue the day of treatment.
- wear loose clothing, thin strap tank top (women) and shorts or loose fitting pants.

Initial Consult: 30 – 45 minutes

I will review the intake form with you. This initial form is to give me a holistic view of your constitution and current condition(s). I will take your pulse, look at your tongue, and I may conduct physical tests if necessary, in order to make a comprehensive diagnosis of your main concern.

Treatment: 30 – 60 minutes

Following the consultation, acupuncture needles will be inserted and left for 10-35 minutes, (no longer that 15 minutes if this is your first acupuncture session). During this time I will leave the room and allow you to relax. I will check in on you after 10 minutes to make sure that you are feeling comfortable. We will discuss a treatment course before you leave your first session.

Follow-up:

With your permission, I will be calling you after two days to see how you are feeling.

Treatment Course:

Treatment frequency depends on a variety of factors: your constitution, the severity and duration of the problem. Acute concerns (recent), usually take at least two treatments per week for a short period. Chronic concerns (longer course of disease/ailment), usually take one treatment per week and takes a longer period of time to show results. Plan on waiting a minimum of one month to see some changes.
Maintenance of health may require once every two weeks or once a month.

Cancellation Policy:

Please be advised that we require 24 hours notice for any cancellations. Cancellations within 24 hours of your appointment time will be charged the full fee, unless the reason for cancellation is an emergency. If you do not

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arrive on time for the appointment, you will be charged for the full appointment, even if there is no time for the treatment.

Herbal Prescriptions

Dr. Stuart is not able to offer refunds on herbal products. ***All herb sales are final.*** Herbal prescriptions are intended only for the patient for whom they have been prescribed.