VITALITY TREATMENT CENTRE

302-1842 OAK BAY AVE. VICTORIA, BC V8R 1C2 **(250) 370-1020** www.vitalitytreatment.ca

ACUPUNCTURE INTAKE: To maximize your treatment time on your first visit please fill out this information to the best of your ability. Confidentiality will be kept in accordance to the Personal Information and Protection Act

Name (Last, First): Gender:	**DOB:** **Age:**
Relationship status: ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other	
Full Address:	**Phone:** **Cell:** **Ok to leave messages?**
Email Address:	
BC Care Card Number: **Extended Medical Insurer:**	**Occupation/** **Primary Activities:**
Family/Referring Doctor:	**Doctor's Phone:**
Emergency Contact: **Relationship to You:**	**Emergency Contact Phone:**
How did you hear about us? **Have you had Acupuncture before?**	

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Medical History:			
	☐ Asthma	☐ High Blood Pressure ☐ Low Blood Pressure	☐ Kidney Disease
	☐ Arthritis	☐ Pacemaker	☐ Liver / Gall Bladder Disease
	☐ Broken Bones	☐ Heart Disease	☐ Seizures
	☐ Cancer	☐ Bleeding Disorder	☐ Stroke
	☐ Colitis	☐ Hepatitis ____	☐ Substance Abuse
	☐ Diabetes	☐ Herpes / Shingles	☐ Thyroid Imbalance
	☐ Gastritis	☐ High Cholesterol	☐ Tuberculosis
	☐ Gout	☐ HIV / AIDS	☐ Bleeding Disorder

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CHIEF COMPLAINTS

Please indicate your chief concerns for your health:

1. ____

2. ____

3. ____

Have you tried any other treatments or therapies for the above concerns and were they effective? Please explain.

Have you been given a specific diagnosis by a health professional for the above? When?

Surgeries / Trauma / Accidents (ex. car accident)

Year	Please Explain:

Medications / Pain Killers / Supplements / Vitamins / Minerals

Name / Strength	Frequency	Reason Taken

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Allergies	
Drug / Environment / Food	Reaction?

HEALTH HABITS

Diet	Are you dieting or avoiding certain foods?			☐ Yes	☐ No
	If yes, please explain:				
	Do you have any problems with eating or appetite? Please explain.				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola / Energy Drinks / Energy Pills	
	# of cups/cans per day?				
Daily Activity	What do you do for daily exercise/activity (ex. walk the dog, running, ski, etc.)?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind? ________________________________ How many drinks per week? ________________				
Tobacco	Do you use tobacco or have used in the past?			☐ Yes	☐ No
	☐ Cigarettes – pks./day ____________________	☐ Chew - #/day _____________	☐ Pipe - #/day ___________	☐ Cigars - #/day ____________	
	☐ # of Years __________	☐ Or Year Quit ___________			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
	Have you ever been treated for substance abuse?			☐ Yes	☐ No
Are you concerned with any of your answers to the above questions?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS (HEART DISEASE, CANCER, MENTAL ILLNESS, ARTHRITIS, ETC.)
Father		
Mother		
Other Relatives:		

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MENTAL HEALTH				
Is stress a major problem for you?	☐	Yes	☐	No
Please rate your stress level on a scale of 0 to 10 (0 = no stress; 10 = extreme stress) __________________				
Do you feel depressed or anxious?	☐	Yes	☐	No
Do you suffer panic attacks or heart palpitations when stressed?	☐	Yes	☐	No
Have you ever attempted suicide or intentionally hurt yourself? When? __________________________________	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself or anyone else?	☐	Yes	☐	No
Have you ever been to a counselor or therapist?	☐	Yes	☐	No

NEURO-PSYCHOLOGICAL (SELECT ALL THAT APPLY)		
☐ Seizures	☐ Lack of Concentration	☐ Poor Memory / Forgetfulness
☐ Tremors / Tics	☐ Depression	☐ Learning Disability
☐ Concussion History	☐ Seasonal Affective Disorder	☐ ADHD
☐ Numbness / Tingling	☐ Irritable / Bad Temper	☐ Bell's Palsy / Trigeminal Neuralgia
☐ Lack of Coordination	☐ Mood Swings	☐ Other:
☐ Loss of Balance	☐ Abuse Survivor / PTSD	

SLEEP				
How many hours of sleep do you get a night on average? _______________________				
Do you have trouble falling asleep?	☐	Yes	☐	No
Do you wake up regularly when trying to sleep?	☐	Yes	☐	No
Do you feel rested upon waking?	☐	Yes	☐	No
Do you feel tired during the day?	☐	Yes	☐	No
Do you suffer from nightmares or frequent dreaming while asleep?	☐	Yes	☐	No

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REPRODUCTIVE HEALTH (AS APPLICABLE)

Age of first menses: ________ Menses every ______________ days Length of Menses: ______________

Please circle ALL that apply with regards to your menses:

Menstrual Flow: Heavy / Light / Irregular / Spotting / Clotted / With Mucous / Other: ______________________________________

Color of Menstruate: Bright Red / Dark Red / Pale Red / Brown / Purple / Black / Other: ____________________________________

PMS: Bloating / Headaches / Breast Tenderness / Abdominal Cramping / Upset Stomach / Food Cravings / Mood Swings / Discharge

Do you experience pain ___ before / ___ during / or ___ after your menses?

Other (please explain):

Number of Pregnancies: Live Births: Abortions: Miscarriages:

Question		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Any problems with vaginal discharge or vaginal dryness?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Please select all that apply.

- ☐ Pre Menopause
- ☐ Menopause
- ☐ Post Menopause
- ☐ Endometriosis
- ☐ PCOS
- ☐ Frequent Yeast Infections
- ☐ Fertility Problems
- ☐ Other:

Type of Birth Control used:		
Do you experience any loss of interest in sex?	☐ Yes	☐ No
Do you or have you ever had a sexually transmitted infection?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Any problems with prostatitis?	☐ Yes	☐ No
Date of last prostate exam? ____		

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OTHER PROBLEMS
Check if you currently have, or have had, any symptoms in the following areas to a significant degree.

GENERAL HEALTH		
☐ Sudden Changes in Energy Levels	☐ Muscle Weakness	☐ Poor or No Appetite
☐ Fatigue / Low Energy	☐ Sweat Easily	☐ Changes in Appetite
☐ Cravings ________________________	☐ Night Sweats	☐ Body Generally Warm / Cold
☐ Weight Loss / Gain	☐ Easy to Bruise	☐ Poor Balance
☐ Frequent Colds and Flus	☐ Bleeding Disorder	☐ Hearing Loss

SKIN, HAIR, & NAILS		
☐ Acne / Pimples	☐ Itchy Skin	☐ Moles / Skin Discoloration
☐ Dandruff / Dry Scalp	☐ Rashes / Hives	☐ Sensitive Skin
☐ Dry / Brittle Nails	☐ Eczema / Psoriasis	☐ Skin Ulcers
☐ Hair Loss	☐ Rosacea	☐ Warts
☐ Frequent Fungal Infections	☐ Other:	

HEAD, EARS, EYES, NOSE, & THROAT		
☐ Headaches	☐ Cataracts	☐ Nose Bleeds
☐ Migraines	☐ Taste / Smell Problems	☐ Sinus Problems
☐ Concussions	☐ Poor Hearing	☐ TMJ Pain / Joint Problems
☐ Dizziness	☐ Ear Aches	☐ Facial Pain
☐ Blurry Vision	☐ Ear Ringing / Tinnitus	☐ Toothaches
☐ Floaters in Vision	☐ Difficulty Swallowing	☐ Recurrent Sore Throat
☐ Eye Strain / Eye Pain	☐ Thirst	☐ Lip / Mouth Sores
☐ Night Blindness	☐ Dry Mouth / Throat	☐ Other:

CARDIOVASCULAR		
☐ High / Low Blood Pressure	☐ Stroke	☐ Cold Hands / Feet
☐ Chest Pain / Angina	☐ TIA History	☐ Swelling of Hands / Feet
☐ Irregular Heartbeat	☐ Pacemaker	☐ Fainting/ Light Headedness
☐ Palpitations	☐ Blood Clots	☐ Shortness of Breath
☐ Heart Attack	☐ Spider Veins / Varicose Veins	☐ Other:

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RESPIRATORY		
☐ Asthma	☐ COPD	☐ Easily Winded
☐ Bronchitis	☐ Emphysema	☐ Phlegm / Expectoration
☐ Cough	☐ Difficult / Painful Breathing	☐ Other Lung Condition:
☐ Cough with Blood	☐ Tight Sensation in Chest	

GASTROINTESTINAL		
☐ Nausea	☐ Acid Reflux / Heartburn	☐ Rectal Pain
☐ Vomiting	☐ Constipation	☐ Blood in Stool
☐ Stomach Ulcers	☐ Diarrhea / Loose Stools	☐ Black Stools
☐ Bad Breath	☐ Abdominal Bloating / Gas	☐ Hemorrhoids
☐ Belching / Hiccups	☐ Abdominal Pain / Cramping	☐ Other:
☐ Indigestion	☐ Chronic Laxative Use	

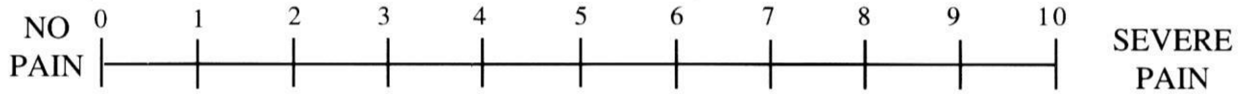
How many bowel movements do you have per day? ____________________ Per week? ______________________________

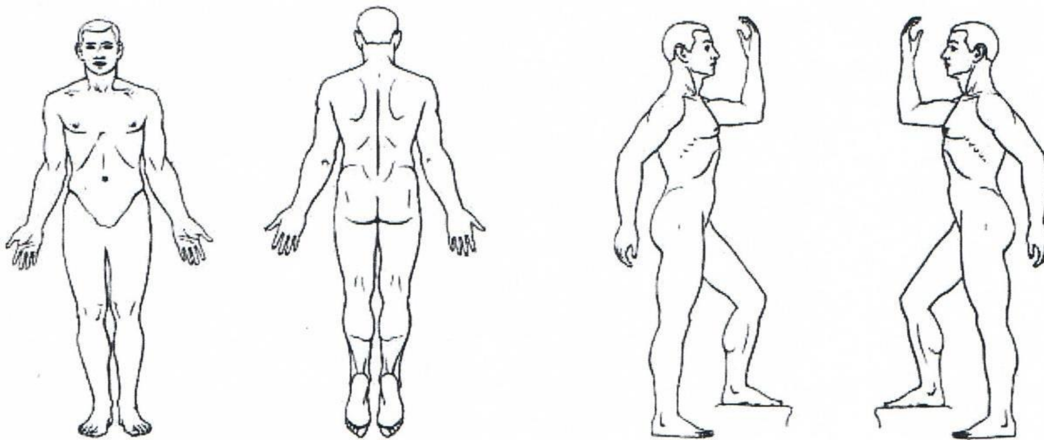
UROLOGY		
☐ Nighttime Urination	☐ Incontinence	☐ Blood in Urine
☐ Frequent Urination	☐ Retention of Urine	☐ Copious Amount of Urine
☐ Painful / Burning Urination	☐ Difficult Urination	☐ Frequent Urinary Tract Infections
☐ Difficulty Emptying Bladder	☐ Urgency to Urinate	☐ Kidney Stones - When? ____________
☐ Loss of Force of Urination	☐ Dribbling after Urination	☐ Other:

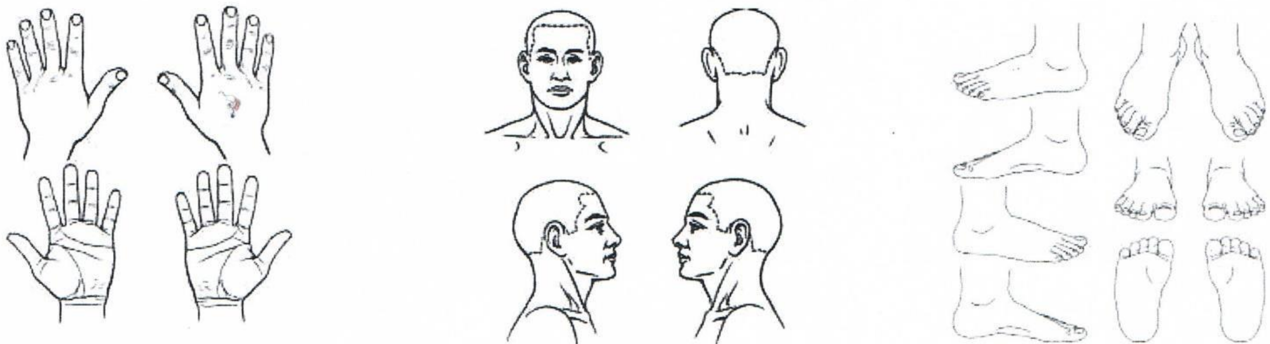
JOINT & MUSCLE CONDITIONS		
☐ Neck Pain	☐ Carpal Tunnel	☐ Arthritis - Type: __________________
☐ Shoulder Pain	☐ Back Pain – Upper / Mid / Lower	☐ Bursitis
☐ Elbow Pain	☐ Hip Pain	☐ Hypermobility
☐ Golfers' / Tennis Elbow	☐ Knee Pain	☐ Sciatica
☐ Hand / Wrist Pain	☐ Foot / Ankle Pain	☐ Muscle Cramps

AREAS OF CONCERN

Please mark the painful areas on the diagrams below and record the type of discomfort you experience (i.e. numbness, tingling, stabbing, sharp, aching, throbbing, etc.). Rate the discomfort on a scale of 0 to 10 (0 = no pain; 10 = excruciating pain).







Do changes in the <u>weather</u> make your problem areas better or worse?

Does applying <u>heat or cold</u> make your problem area better or worse?

What do you to try to alleviate your symptoms and does it help?

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Patient Informed Consent to Treatment

I, ____________________________, have discussed with my Acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to treatment by Traditional Chinese Medicine/Acupuncture and **understand that I may withdraw my consent and halt my participation at any time.**

1. I understand that Acupuncture is a low risk procedure which involves the use of sterile, single-use needles to penetrate the skin. Additional treatment techniques used under the scope of Traditional Chinese Medicine can include, but are not limited to: acupressure/tui na, the electrical stimulation of needles, cupping, moxibustion (a type of warming plant) and gua sha (stroking skin with instrument). Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.

2. My practitioner has informed me of the risks and symptoms of treatments, which can include but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I accept the risks involved with my procedure.

3. I will inform my practitioner **if I currently have** or **develop** any **major health issues**, if I suffer from any type of major bleeding disorder, or if I use a pacemaker. I understand that **I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to: HIV, TB, and/or Hepatitis.**

4. I understand that acupuncture can be very beneficial in the treatment of symptoms during and after pregnancy. I must inform my practitioner if I become pregnant or am trying to become pregnant during the course of treatment so that they may avoid points that may induce premature labour or miscarriage.

5. I understand that there are no guarantees for results with treatment. The length of my treatment often depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

6. I am responsible for the full and prompt payment after services have been rendered, or for the cost of a missed (or cancelled without 24 hours notice) appointment.

7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine/Acupuncture treatments.

Patient/ Guardian Signature _____________________ Date________________________

Practitioner Signature _______________________________ Date________________________

I authorize Vitality Treatment Centre and its associated practitioners to communicate with my Medical Doctor/ Referring Health Care Practitioner regarding concerns directly related to my treatment. I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Patient/ Guardian Signature: ________________________ Date________________________