Vitality Clinic

Complete wellness under one roof

Patient Information

Date:

First Name: **Last Name:**

Card Care Number (PHN) **Birthday (MM/DD/YY)** **Age:**

Home Address

City **Postal Code**

Home Telephone **Cell Phone**

Email

Would you like an email reminder for your next appointment? ☐ Yes ☐ No

Please note that we require minimum 48 hours notice for any cancellations or changes or you may incur a penalty. A fee will be charged to your account for all missed appointments. **Signature:**

Occupation **Business/Employer**

Do you have extended health insurance? ☐ Yes ☐ No

Is this treatment going to be part of an ICBC or WCB claim? ☐ Yes ☐ No. If yes, please bring all of your claim information.

May the Doctor and/or Staff contact you at work? ☐ Yes ☐ No **Work Telephone:**

Name of current General Practitioner (MD)

Date of last visit to GP: (MM/DD/YY) **Reason for last visit:**

Are you seeing a Medical Specialist? ☐ Yes ☐ No **Name of Specialist**

Reason for seeking specialist?

Emergency Contact Name: **Number:**

Relation to you:

How did you learn about Vitality Clinic?

Office use only: MSP ☐ Yes ☐ No ☐ CE ☐ W/C

Confidential Health Information

Main health complaint

Other complaints

Have you had previous care from a: ☐ Chiropractor ☐ Massage Therapist ☐ Acupuncture/TCM?

If yes, name of practitioner: **Date of last visit (in the past two years):**

Have you had any recent X-rays, CT Scans or MRIs? ☐ Yes ☐ No. If yes, when:

Please list any hospitalizations, surgeries or major accidents (including MVA's) you've had and the date.

Please list any Medications or Supplements you are taking and state reasons for taking it.

Overall stress level: ☐ None ☐ Low ☐ Medium ☐ High

Reasons:

How often do you exercise: **Type of exercises:**

Do you currently smoke? ☐ Yes ☐ No. **How many per day:** **How long have you smoked?**

What would you like to gain from today's visit? What are the two most important health goals?

For Women

Are you pregnant ☐ Yes ☐ No ☐ Maybe. If yes, due date?

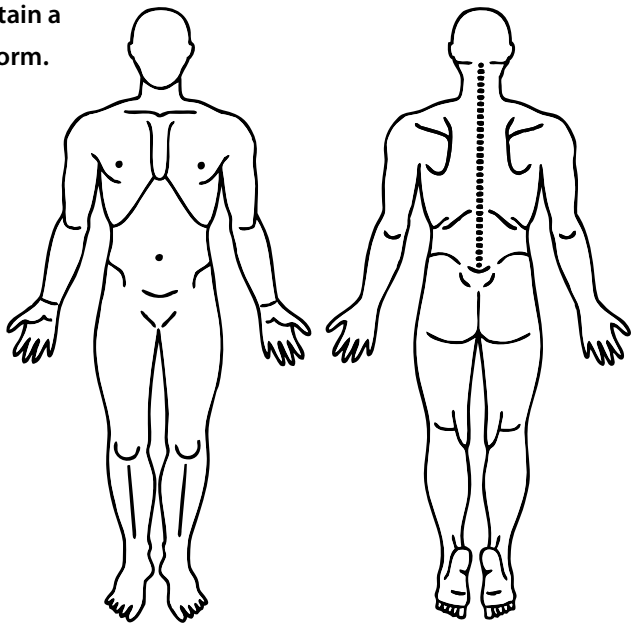
Do you have children? ☐ Yes ☐ No. If yes, by: ☐ natural ☐ caesarean delivery

Menstrual cycle: ☐ regular ☐ irregular ☐ cramps ☐ painful cycle

Date of your last breast exam:

Review of Systems

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete the following form. If you are having any difficulty with the following, please check the box:



General
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain

Head
- ☐ Headache
- ☐ Dizziness
- ☐ Head Trauma
- ☐ Fainting
- ☐ Blacking out

Eyes
- ☐ Itching/redness
- ☐ Change in vision
- ☐ Cataracts
- ☐ Light sensitivity
- ☐ Flashes in vision
- ☐ Spots in vision
- ☐ Glaucoma

Ears
- ☐ Ringing/ tinnitus
- ☐ Impaired Hearing
- ☐ Earache
- ☐ Dizziness
- ☐ Discharge

Mouth and Throat
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Sore throat
- ☐ Jaw/TMJ problems
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Goiter

Nose
- ☐ Hayfever
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus problems

Lungs
- ☐ Difficulty breathing
- ☐ Shortness of breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Infections

Vascular
- ☐ Angina
- ☐ Murmurs
- ☐ Heart disease
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Cold feet/hands
- ☐ Leg cramps
- ☐ Calf pain
- ☐ Varicose veins
- ☐ Low blood pressure
- ☐ High blood pressure

Gastro-intestinal
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Liver disease
- ☐ Gall bladder disease
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernias

Urinary
- ☐ Difficulty urinating
- ☐ Pain urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Bed-wetting
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Kidney stones

Neurological
- ☐ Seizures/epilepsy
- ☐ Strokes
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Difficulty walking
- ☐ Poor coordination
- ☐ Paralysis
- ☐ Speech problems
- ☐ Loss of memory

Muscle & Bone
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Stiffness
- ☐ Muscle ache
- ☐ Foot trouble
- ☐ Arthritis
- ☐ Bone pain
- ☐ Fractures
- ☐ Disclocations

Skin
- ☐ Rash
- ☐ Itching/hives
- ☐ Changes in moles
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema

Endocrine
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hormone therapy
- ☐ Thyroid problems
- ☐ Heat/cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive sweating
- ☐ Night sweats

Emotional
- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety/nervousness
- ☐ Tension
- ☐ Phobias
- ☐ Alcohol/drug abuse

Conditions
- ☐ AIDS/HIV
- ☐ Eating disorders
- ☐ Heart condition
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Alcoholism
- ☐ Cancer/tumor
- ☐ Polio
- ☐ Parkinson's
- ☐ Multiple sclerosis
- ☐ Gout
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Hepatitis
- ☐ Migraines

Health History

Immunizations

Did you receive general childhood vaccinations? ☐ Yes ☐ No

Check any other vaccines taken: ☐ Hepatitis A ☐ Hepatitis B ☐ Flu shot ☐ Others

Allergies Please list all allergies or hypersensitivities in the following categories.

Medications

Foods

Environmental/chemical

Medications

Medications Please check if you take or use any of the following.

☐ Alcohol ☐ Antacids ☐ Anti-inflammatory ☐ Caffeine ☐ Cortisone ☐ Laxatives

☐ Marijuana ☐ Pain relievers ☐ Sleeping pills ☐ Tranquilizers ☐ Other drugs

Were you ever on antibiotics for more than 1 month over the last 10 years? ☐ Yes ☐ No

Have you ever used probiotics (acidophilus) following antibiotic use? ☐ Yes ☐ No

Family History Please check if you have a family history of any of the following.

☐ Arthritis ☐ Asthma/allergies ☐ Cancer ☐ Depression ☐ Diabetes ☐ Drug/alcohol abuse

☐ Epilepsy ☐ High blood pressure ☐ High cholesterol ☐ Kidney disease ☐ Mental illness ☐ Stroke

☐ Other ☐ I don't know my family history

Sleep

Time you retire **Time you wake up**

Do you have problems falling asleep? ☐ Yes ☐ No **Staying asleep?** ☐ Yes ☐ No

Do you wake rested in the morning? ☐ Yes ☐ No

Diet

Do you follow any particular diet regimens or restrictions? ☐ Yes ☐ No

Describe a typical day's dietary intake. **Fluids**

Breakfast **Lunch**

Dinner **Snacks**

Acupuncture/TCM Consent Form

Please read the following carefully and enquire if you have any questions or concerns.

We take this opportunity to welcome you to our clinic. Vitality Clinic utilizes the principles of Acupuncture Medicine and other supportive therapies to assist the body 's own ability to heal, and to improve the quality of life and health through natural means. A Registered Acupuncturist or TCM Doctor will conduct a thorough case history and physical examination, and may utilize specific blood, urinary or other laboratory reports as part of your treatment work-up.

Statement of Acknowledgement

As a patient of Vitality Clinic, I have read the information and understand that the form of medical care to be given me is based on Acupuncture and/or TCM and other supportive principles and practices. I recognize that even the gentlest therapies have potential complications in certain physiological conditions or in very young children or those on multiple medications. The information I have provided is complete and inclusive of all health concerns, including risk of pregnancy and all medications, including over-the-counter drugs.

The slight health risks of some Acupuncture and/or TCM treatments include but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and spasms; disc injuries from spinal manipulations. I also recognize the following:

- Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practise in British Columbia.
- I understand that a record of my visits will be kept. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am aware that I am responsible for payment at the time services are rendered.
- I am aware that 48 hours notice must be given for cancellation of an appointment or a cancellation fee will be applied.
- I understand that the RA/TCM reserves the right to determine which cases fall outside his/her scope of practice, in which event the appropriate referral will be recommended. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agency to gather information without stating so. I accept full responsibility for any fees incurred during care and treatment.

I authorize any information I have provided to be shared with any practitioner working within Vitality Clinic.

Signature of patient **Date (DD/MM/YY)**

Full name (please print)

Signature of Registered Acupuncturist/TCM Doctor **Date (DD/MM/YY)**

Full name (please print)