# PATIENT INFORMATION INTAKE FORM

The personal information on this form is collected under the Freedom of Information and Protection of Privacy Act for the purpose of patient intake and assessment
by Dale Leicht RAc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME:**  | First & Last Name |  | **DATE:**  | Date. |
|  ***First Name Last Name Month/Day/Year***  |
| **DATE OF BIRTH:**  | M/D/Y. | **AGE:**  | Age | **WT:**  | Wt | Kg/Lbs | **HEIGHT:**  |  Ht |
|  ***Month/Day/Year***  |   |
| **How do you identify? (check all that apply):** [ ]  **Male** [ ]  **Female** [ ]  **Transgender** [ ]  **Non-Binary** [ ]  **MTF** [ ]  **FTM** [ ]  **Intersex** [ ]  **Genderqueer** [ ]  **other:**  |
| **HOME ADDRESS:**  | Address |
| ***City/Town:***  | City/Town | ***Province:*** | Province | ***Postal Code:***   | Postal  |
| **HOME PHONE:**  | Phone # | **CELL PHONE:**  | Phone # |
| **WORK PHONE:**  | Phone # | **E-MAIL ADDRESS:**  | Email |
| **Dale’s acupuncture offers the service of appointment reminders by email or text. I understand the risks/benefits of email or text transmission and request that future reminders or follow ups be sent electronically to the above email address or cell number (please check one):** [ ]  **YES** [ ]  **NO**  |
| **OCCUPATION:**  | Occupation. | **Have you received acupuncture treatments before?** | [ ]  **Yes** [ ]  **No** |
| **Family Physician:**  | Name. Phone # optional |
| **Have you discussed the use of acupuncture with your medical physician concerning your reason for treatment?** [ ]  **YES** [ ]  **NO** |
|  **Emergency / Family Contact Details** |
| **Name:**  | First & Last name | **10 Phone #:**  | Phone # |
| **Relationship:**  | Relationship | **20 Phone #:** | Phone # |
| Medical insurance provider  | Insurance provider | **ID #**  | Insurance ID number |
| **Group #**  | Insurance Group number | **Section #** | Insurance section number |
| **Reason(s) for your visit:** *(Please list your health concerns & complaints in order of importance)* Reason Onset Frequency Severity |
| e.g. Headaches, June 2021, 4x/week, 5/10 or mild/mod/sever |
| 1. Click or tap here to enter text. |
| 2. Click or tap here to enter text. |
| 3. Click or tap here to enter text. |
| What are your goals for this visit? |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FAMILY HISTORY:**  | **Father**  | **Mother**  | **Brother(s)**  | **Sister(s)**  | **Child(ren)**  |
| **Overall Health:** ***(Good/Poor)***  | Choose an item. | Choose an item. | Choose an item. | Choose an item. | Choose an item. |
| **Check if Applicable:**  |  |  |  |  |  |
| **Cancer**  | [ ]  | [ ]  | [ ]  | [ ]   | [ ]   |
| **Diabetes**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Heart Disease**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Hypertension**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Stroke**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Epilepsy**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Mental Illness**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Tuberculosis**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Other**  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|  **Do you have a contagious disease (e.g. hepatitis, tuberculosis, flu) at this time?**  | [ ]  **Yes** [ ]  **No**  |
| If yes: please specify here. |
|  **Have you ever had surgery or been hospitalized?** (You may also attach a separate list) | [ ]  **Yes** [ ]  **No**  |
|  Click or tap here to enter text. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |
|  **Are you allergic to any medications, herbs, foods?**  | [ ]  **Yes** [ ]  **No**  |
| Medications:  | Click here to enter text. |
| Herbs:  | Click here to enter text. |
| Foods:  | Click here to enter text. |
| Other:  | Click here to enter text. |

|  |
| --- |
| **Are you taking medications for any of the following conditions?** *(Check if applicable)* |
|   |  | **Name of Medication**  |   |  | **Name of Medication**  |
| Heart/Blood Pressure  | [ ]   | Click here to enter text. | Laxatives  | [ ]   | Click here to enter text. |
| Steroids/Tranquilizers  | [ ]   | Click here to enter text. | Antacids (Stomach)  | [ ]  | Click here to enter text. |
| Pain Relievers  | [ ]   | Click here to enter text. | Thyroid Medication  | [ ]   | Click here to enter text. |
| Antibiotics  | [ ]   | Click here to enter text. | Hormone Replacement  | [ ]   | Click here to enter text. |
|  **Please list any herbs or vitamins you are currently taking:**  |
| Herbs:  | Click or tap here to enter text. |
| Vitamins:  | Click or tap here to enter text. |
| Other:  | Click or tap here to enter text. |
|  **Describe your appetite:**  |  |  |
| [ ]  Excessive  | [ ]  Good  | [ ]  Fair  | [ ]  Poor  | [ ]  Absent |
| **Do you have any food cravings?** (e.g. sweets, salt) |  | [ ]  **Yes** [ ]  **No**  |
| If Yes, please specify here. |
| **Do you have any digestive disturbances?**  |  | [ ]  **Yes** [ ]  **No**  |
| If Yes, please describe here.   |
| **Do you have any of the following lifestyle habits?**  |
| Caffeinated Drinks (e.g. Coffee, Tea, Pop)  | [ ]  Yes  | [ ]  No  | If yes, how much? (e.g. 2/day)  |  Enter here. |
| Smoking /Tobacco | [ ]  Yes  | [ ]  No | If yes, how much? (e.g. 2/day)  | Enter here. |
| Alcohol  | [ ]  Yes  | [ ]  No | If yes, how much? (e.g. 2/day)  | Enter here. |
| Recreational Drugs  | [ ]  Yes  | [ ]  No | If yes, specify type & how much.  | Enter here. |
| Other (Describe)  | [ ]  Yes  | [ ]  No | Describe here. |

|  |
| --- |
| **Please check boxes that are relevant to you pertaining to your cardiovascular conditions:**  |
| High Blood Pressure  | [ ]   | Lightheaded  | [ ]   | Fast heartbeat  | [ ]   | Orthostatic hypotension  | [ ]   |
| Low Blood Pressure  | [ ]   | Chest Pain  | [ ]  | Palpitations  | [ ]  | Phlebitis  | [ ]  |
| Fainting  | [ ]   | Slow heartbeat  | [ ]  | Irregular heartbeat  | [ ]  | Heart attack  | [ ]  |
|  **Please check boxes that are relevant to you pertaining to your gastrointestinal conditions:**  |
| Nausea  | [ ]  | Diarrhea  | [ ]  | Undigested food in stools  | [ ]  | Hemorrhoids  | [ ]  |
| Vomiting  | [ ]  | Constipation  | [ ]  | IBS  | [ ]  | Gastritis  | [ ]  |
| Acid regurgitation  | [ ]  | Laxative use  | [ ]  | Stomach cramps  | [ ]  | Enteritis  | [ ]  |
| Gas  | [ ]  | Black stools  | [ ]  | Itchy anus  | [ ]  | Hard stools  | [ ]  |
| Hiccup  | [ ]  | Blood in stools  | [ ]  | Burning anus  | [ ]  | Bad breath  | [ ]  |
| Bloating after meals  | [ ]  | Mucus in stools  | [ ]  | Rectal pain  | [ ]  | Gurgling sounds  | [ ]  |
| Intestinal cramping  | [ ]  | Ulcerative colitis  | [ ]  | Loose stools  | [ ]  | # of bowel movements per day  |   |
|  **Please check boxes that are relevant to you pertaining to the head, eyes, nose, and throat:**  |
| Glasses  | [ ]  | Blurred vision  | [ ]  | TMJ  | [ ]  | Excessive saliva  | [ ]  |
| Eye strain  | [ ]  | Night blindness  | [ ]  | Gum disease  | [ ]  | Sinus problems  | [ ]  |
| Red eyes  | [ ]  | Glaucoma  | [ ]  | Sore gums  | [ ]  | Clear throat often  | [ ]  |
| Itchy eyes  | [ ]  | Cataracts  | [ ]  | Bleeding gums  | [ ]  | Recurrent sore throat  | [ ]  |
| Spots in eyes  | [ ]  | Grinding teeth  | [ ]  | Sores on lips  | [ ]  | Swollen glands  | [ ]  |
| “Floaters” in vision  | [ ]  | Soft teeth  | [ ]  | Sores on tongue  | [ ]  | Lumps in throat  | [ ]  |
| Poor vision  | [ ]  | Multiple cavities  | [ ]  | Dry mouth  | [ ]  | Enlarged thyroid  | [ ]  |
| Nose bleeds  | [ ]  | Ringing in ears  | [ ]  | Poor hearing  | [ ]  | Earaches  | [ ]  |
| Headaches  | [ ]  | Migraines  | [ ]  | Concussions  | [ ]  |  Nose bleeds |   |
|  **Please check boxes that are relevant to you pertaining to your respiratory conditions:**  |  |
| Feeling short of breath  | [ ]  | Lightheaded  | [ ]  | Fast heartbeat  | [ ]  | Orthostatic hypotension  | [ ]  |
| Difficulty breathing lying down  | [ ]  | Chest Pain  | [ ]  | Tightness in chest | [ ]  | Chronic cough | [ ]  |
| Productive cough with:  | [ ]  | A lot of sputum  | [ ]  | Sticky sputum  | [ ]  | Clear sputum  | [ ]  |
| Catch colds frequently  | [ ]  | Very little sputum  | [ ]  | Green sputum  | [ ]  | Blood in sputum  | [ ]  |

|  |  |
| --- | --- |
| **Please check boxes that are relevant to you pertaining to your sleep patterns:**  |  |
| Insomnia  | [ ]  | Problems staying asleep  | [ ]  | Dream disturbed sleep  | [ ]  |
| Troubles falling asleep  | [ ]  | Wake up tired  | [ ]  | Nightmares  | [ ]  |
| [ ]   | Waking up in the night: time(s) that you wake at:  |  Click or tap here to enter text. |  |
|  **Please check boxes that are relevant to you pertaining to the condition(s) of your skin and hair:**  |
| Rashes  | [ ]  | Eczema  | [ ]  | Dandruff  | [ ]  | Premature grey hair  | [ ]  |
| Hives  | [ ]  | Psoriasis  | [ ]  | Itchy skin  | [ ]  | Alopecia/hair loss  | [ ]  |
| Ulcerations  | [ ]  | Shingles  | [ ]  | Fungal infections  | [ ]  | Brittle hair  | [ ]  |
| Dry skin  | [ ]  | Oily skin  | [ ]  | Acne  | [ ]  | other | [ ]  |
|  **Please check boxes that are relevant to you pertaining to your genito-urinary conditions:**  |  |
| Painful urination  | [ ]  | Cloudy urination  | [ ]  | Dark yellow urine  | [ ]  | Burning urination  | [ ]  |
| Frequent urination  | [ ]  | Scanty urination  | [ ]  | Light yellow urine  | [ ]  | Retention of urine  | [ ]  |
| Copious urination  | [ ]  | Urination at night  | [ ]  | Clear urine  | [ ]  | Frequent bladder infections  | [ ]  |
| Frequent kidney infections  | [ ]  | Urinary incontinence  | [ ]  |  other |
|  **Please check boxes that are relevant to you pertaining to your neuropsychological conditions:**  |
| Seizures  | [ ]  | Tics  | [ ]  | Anxiety  | [ ]  | Abuse survivor  | [ ]  |
| Numbness  | [ ]  | Poor memory  | [ ]  | Irritability  | [ ]  | ADHD  | [ ]  |
| Tingling  | [ ]  | Depression  | [ ]  | Easily stressed  | [ ]  | Parkinson’s  | [ ]  |
| Trigeminal neuralgia  | [ ]  | Bell’s palsy  | [ ]  | Fainting  | [ ]  | other  |   |
|  **Please check boxes that are relevant to you pertaining to your musculoskeletal conditions:**  |
| Neck pain  | [ ]  | Hand pain  | [ ]  | Abdominal pain  | [ ]  | Leg pain  | [ ]  |
| Shoulder pain  | [ ]  | Finger pain  | [ ]  | Upper back pain  | [ ]  | Knee pain  | [ ]  |
| Arm pain  | [ ]  | Chest pain  | [ ]  | Mid back pain  | [ ]  | Ankle pain  | [ ]  |
| Elbow pain  | [ ]  | Rib pain  | [ ]  | Lower back pain  | [ ]  | Toe pain  | [ ]  |

|  |  |
| --- | --- |
|  **FOR MALES ONLY:** *(Check if applicable)* |  |
| Testicular Pain  | [ ]  | Sexually Transmitted Disease  | [ ]  |
| Impotence/Erectile Dysfunction  | [ ]  | Prostate Problems  | [ ]  |

|  |
| --- |
| **FOR FEMALES ONLY:**  |
| Age of First Menses  |  Year Years Old  |
| Duration of Menses (e.g. 3-5 days)  |  Days Days  |
| Length of Cycle (e.g. 28-30 days)  |  Days Days  |
| ***Check if applicable:***  |
| Regular Menses  | [ ]  | Heavy/Excessive Flow  | [ ]  |
| Pre-Menstrual Syndrome  | [ ]  | Spotting/Bleeding between cycles  | [ ]  |
| Painful Menses  | [ ]  | Menstrual Problems  | [ ]  |
| Clots  | [ ]  | Menopausal Problems  | [ ]  |
| Discharge  | [ ]  | Breast Lumps  | [ ]  |
| Sexually Transmitted Disease  | [ ]  | Other:  | [ ]  |
| **Do you use birth control pills?** [ ]  **Yes** [ ]  **No**  |
| If yes, please list the type & brand |  |
| **Are you pregnant?** [ ]  **Yes** [ ]  **No**  |
| **Have you ever been pregnant?** [ ]  **Yes** [ ]  **No**  |
| If yes, please indicate:  |  |
| Number of PregnanciesClick or tap here to enter text. | Problems in Pregnancy [ ]  Yes [ ]  No |
| Number of Miscarriages Click or tap here to enter text. | Problems in Delivery [ ]  Yes [ ]  No |
| Number of Abortions Click or tap here to enter text. |
| **If you answered yes to having had problems with a pregnancy or delivery, please describe those problems:**  |
| Click or tap here to enter text. |
|  **Describe any concerns you have regarding your comfort and safety during an acupuncture treatment such as: needle phobia, bleeding disorders (e.g. haemophilia), pace maker, medication pump, blood pressure, infections, compromised skin (e.g. lesions, cuts, burns).**  |
|  Click or tap here to enter text. |
| **What type of treatment sensation are you comfortable with? (1 mild to 10 strong)**  | # |
| Click or tap here to enter text. |

Electronic Signature

You now have the option to sign this form electronically. If you elect to do so, you hereby consent and agree that your use of keypad, mouse or device to click the check box below constitutes your signature, acceptance and agreement to the Consent and Signature forms immediately below as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

*Note: Please ensure that you have reviewed and have any question you may have concerning consents before applying your Electronic Signature.*

[ ]  I give my consent to the “Patient Informed Consent to Treatment” and “Consent to Collect and Release Information” as outlined below.

# Patient Informed Consent to Treatment

# Dale Leicht. Reg #102041, 780-718-9015

I, or the person listed below, do hereby voluntarily consent to be treated with Traditional Chinese Medicine (TCM) or Acupuncture as administered by Dale Leicht RAc.

I understand Acupuncture is performed by: the insertion of needles through the skin or, by the application of heat to the skin or, by both at certain points on or near the surface of the body in an attempt to restore normal physiological body functions, modify or prevent pain perception.

I have been made aware that TCM utilizes a range of modalities including but not limited to acupuncture, moxibustion, cupping, tuina, acupressure, gua sha, and TDP heat lamp. I understand any of these modalities may be used in combination during my treatment sessions.

I have been made aware of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, fainting, temporary pain or discomfort, soreness, bruising, minor bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.

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 at not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.

I understand acupuncture has been safely practiced for centuries but no guarantees are given to me concerning the effectiveness of treatments and I am free to discontinue treatment at any time.

I am responsible for the full and prompt payment after services have been rendered.

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 treatments.

I have carefully read and understand all the foregoing and am fully aware of what I am signing. I understand my responsibilities as a patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Guardian Name Patient/Guardian Signature Date**

**(*Please print) (month/day/year)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner Signature DATE**

**(*Please print) (month/day/year)***

# Consent to Collect and Release Information

# Dale Leicht. Reg #102041, 780-718-9015

I­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or my appointed representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print) (Print)

**Consent** **Do not consent** for Dale Leicht to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.

In terms of information, the Clinic may collect any of the following:

* Contact information
* Personal or family medical history
* Medical insurance or billing/account information

In cases of emergencies or life-threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

**How Your Information Will Be Used**

Your personal information can be used or disclosed for the following reasons:

* For billing or account purposes
* To assist third-party insurance companies with insurance claims
* Referring your medical history to another health practitioner or health care provider
* To seek advice for potential treatment options
* To prevent or assist patients in cases of emergencies or threat to their health and safety
* To fulfill any obligations as mandated by law

**Patient Access to information**

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records be limited are:

* cases where access to information causes a threat to your life or personal health
* Where the law disallows access to information
* In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

[If applicable] I understand that a reproduction or translation fee may be incurred in accordance with the clinic’s fee schedule.

**Acknowledgment**

I allow for medical personnel to use and disclose my information as outlined above.

I understand that I can access my personal health information except as outlined above.

I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Guardian Name Patient/Guardian Signature Date**

***(Please print)* *(month/day/year)***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

Practitioner Signature Date