NIR SAAR R.AC
P: 226.979.0080
E: INFO@ZEN-NEEDLE.CA

Patient Intake Form

Patient Information		
Last Name:	First Name:	Sex M / F
Home Address (City, Province, Postal Code)		Date of Birth:
Phone: Email:		Occupation:
Emergency Contact Name:	Email: Phone:	

Please describe your main concerns:
1.
2.
3.

Do you have any of the following infectious diseases? (Please circle):
Hepatitis Type (A, B, C, D), HIV Positive, Tuberculosis, Herpes (Oral, Genital), Any STD's? Other? Do you have any Infectious skin conditions; where?

Past Surgeries or Medical Procedures:			
	Reason for surgery	When	Location on the body
Surgery 1			
Surgery 2			
Surgery 3			

Major Physical Trauma (Car Accident, Fall, Head Trauma, Etc):	
Birth	
Childhood	
Adolescence	
Adulthood	

Are you currently taking any medications? (Y/N) Please list:			
	Name of Medication	Reason for taking	Since when
Med 1			
Med 2			
Med 3			

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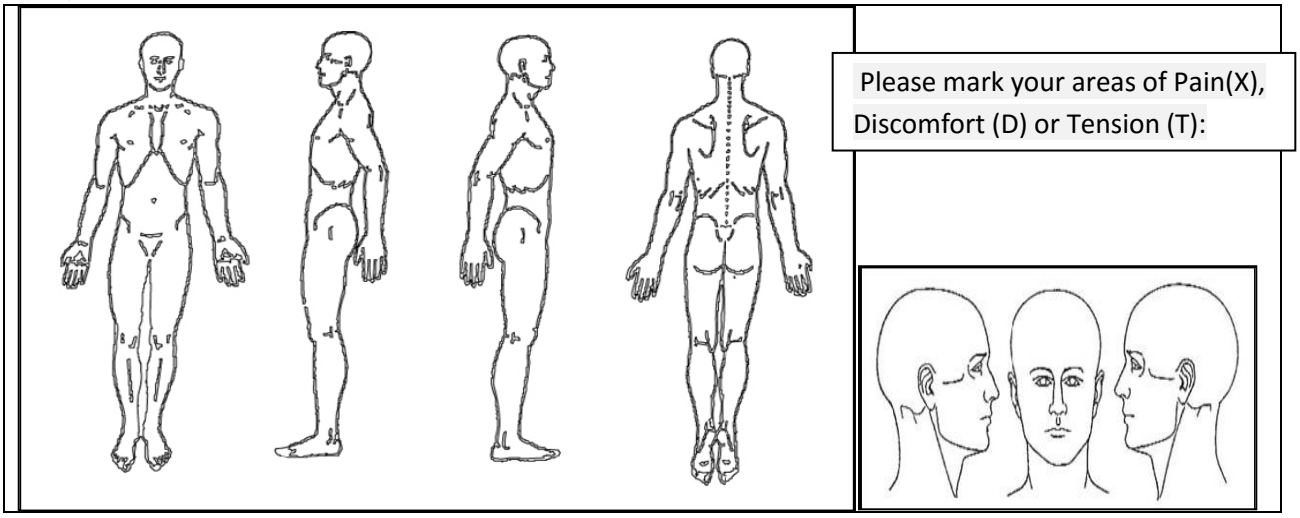

Please mark your areas of Pain(X), Discomfort (D) or Tension (T):

Personal History - Major Conditions			
☐ Arthritis	☐ Liver/Gall Bladder Disease	☐ Chronic Fatigue	☐ Lyme Disease
☐ Cancer	☐ Pancreatitis	☐ Weight Loss/Gain	☐ Thyroid Imbalance
☐ Alcoholism	☐ Kidney Disease	☐ Reduced Immunity	☐ Chronic Pain
☐ Diabetes	☐ Hypo/Hyperglycaemia	☐ Fibromyalgia	☐ Tumour
Skin and Hair			
☐ Rashes	☐ Hives/Allergic Dermatitis	☐ Ulcerations	☐ Eczema/Psoriasis
☐ Itchy skin	☐ Fungal Infection		

Head, Eyes, Ears, Nose and Throat			
☐ Dizziness	☐ Difficulty swallowing	☐ Eye pain	☐ Headaches
☐ Sinus Infection	☐ Recurrent sore throat/Colds	☐ Jaw clicks/locks	☐ Migraines
☐ Earaches	☐ Spots in front of eyes	☐ Blurred Vision	☐ Night Blindness
☐ Ringing in ears	☐ Sores on lips/tongue	☐ Cataracts	☐ Facial pain
☐ Poor hearing	☐ Dental problems	☐ Grinding Teeth	☐ TMJ
Cardiovascular / Circulation			
☐ Chest pain or pressure	☐ Irregular Heart beat	☐ Palpitations	☐ Easy to faint
☐ Cold hands/Feet	☐ Swelling of hands/feet	☐ Blood Clotting prob.	☐ DVT
☐ Pressure in chest	☐ High blood pressure	☐ Low blood pressure	☐ Anemia
Respiratory			
☐ Cough/Wheezing	☐ Coughing Blood	☐ Bronchitis	☐ Emphysema
☐ Asthma	Other:		
Gastrointestinal			
☐ Nausea	☐ Vomiting	☐ Chronic Diarrhoea	☐ Constipation
☐ Blood in stool	☐ Gas	☐ Food Intolerance	☐ Acid reflux/GERD
☐ IBS/Crohn's	Other:		

Genito-Urinary			
☐ Genital Herpes	☐ Frequent urination	☐ Blood in urine	☐ Burning urination
☐ Kidney stones	☐ Urinary tract infections	Other:	

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Gynecological / Reproductive			
☐ Ovarian Cysts	☐ Vaginal discharge	☐ PMS	☐ Irregular menstruation
☐ Painful menstruation	☐ Endometriosis	☐ Uterine / Ovarian Fibroids	☐ Fibrocystic breast tissue
☐ Abortions(When):	☐ Pregnancies(How many):	☐ Caesarean births(How many):	☐ Infertility
Birth control? ☐ Yes ☐ No:		Since when?_____	Type:_____

Psychological / Neurological			
☐ Seizures	☐ Bad Temper/Irritability	☐ Areas of numbness	☐ Vivid dreams
☐ Lack of coordination	☐ ADD/ADHD	☐ Easily susceptible to stress	☐ Waking up at night:
☐ Anxiety/Panic Attacks	☐ Vertigo/Dizziness	☐ Seasonal Affective Disorder	☐ Depression
☐ Nervousness	☐ Concussion	☐ Poor Sleep	☐ Bi-Polar Disorder
Have you ever been treated for emotional problems?		☐ Yes ☐ No	
Have you ever considered or attempted suicide?		☐ Yes ☐ No	
Have you ever been treated for substance abuse?		☐ Yes ☐ No	
Comments: Please inform us of any other problems you would like to discuss:			

I hereby declare that the information that I have given above regarding my health condition is accurate and true to the best of my knowledge.

Signature of Patient:_____ Date:_____

Patient Informed Consent to Treatment

I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. **Additional treatment methods** can include, but are not limited to: acupuncture, acupressure, the Electrical stimulation of needles, Cupping or Moxibustion, Gua sha, and **Structural Techniques**. 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 freely 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.
4. 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.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment 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.*
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 treatments.

Patient Name:	Signature:	Date: