PATIENT INFORMATION INTAKE FORM

The personal information on this form is collected under s.33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of patient intake and assessment at MacEwan University. Questions concerning this collection should be directed to the Lead, Privacy and Information Management at privacy@macewan.ca

NAME:				**DATE:**
First Name	***Last Name***			***Month/Day/Year***
DATE OF BIRTH:	**AGE:**	**WEIGHT:**	**HEIGHT:**	**Gender:**
Month/Day/Year				**Preferred Pronoun:**
HOME ADDRESS:				
Street				
City/Town	***Province***			***Postal Code***
HOME PHONE:		**CELL PHONE:**		
WORK PHONE:		**E-MAIL ADDRESS:**		

EMERGENCY CONTACT: _____ **PHONE NUMBER (s):** _____

RELATIONSHIP: _____ _____

MacEwan University offers the service of appointment reminders by email.
I understand the risks/benefits of email transmission and request that future reminders be sent electronically to the above email address (please check one): ____ YES ____ NO

OCCUPATION:

HOW DID YOU HEAR ABOUT THE CLINIC?

FAMILY HISTORY:	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Child(ren)**
Overall Health: ***(Good/Poor)***					
Check if Applicable:					
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

HEALTH HISTORY: *(Please list your health concerns and complaints in order of importance)*
1.
2.
3.
4.

Do you have a contagious disease (e.g. hepatitis, tuberculosis, flu) at this time? ☐ **Yes** ☐ **No**
If yes, please specify:

Have you ever had surgery or been hospitalized? ☐ **Yes** ☐ **No**
If yes, please describe circumstances and when it occurred:

Are you allergic to any medications, herbs, foods? ☐ **Yes** ☐ **No**
Medications:
Herbs:
Foods:
Other:

Are you taking medications for any of the following conditions? *(Check if applicable)*

		Name of Medication			**Name of Medication**
Heart/Blood Pressure	☐		Laxatives	☐	
Steroids/Tranquilizers	☐		Antacids (Stomach)	☐	
Pain Relievers	☐		Thyroid Medication	☐	
Antibiotics	☐		Hormone Replacement	☐	

Please list any herbs or vitamins you are currently taking:
Herbs:
Vitamins:
Other:

Describe your appetite:

☐ Excessive	☐Good	☐ Fair	☐ Poor	☐ Absent

Do you have any food cravings? (e.g. sweets, salt) ☐ **Yes** ☐ **No**
If yes, please specify:
Do you have any digestive disturbances? ☐ **Yes** ☐ **No**
If yes, please describe:

Do you have any of the following habits?			
Caffeinated Drinks (e.g. Coffee, Tea, Pop)	☐ Yes ☐ No	If yes, how much? (e.g. 2/day)	
Smoking	☐ Yes ☐ No	If yes, how much? (e.g. 2/day)	
Alcohol	☐ Yes ☐ No	If yes, how much? (e.g. 2/day)	
Recreational Drugs	☐ Yes ☐ No	If yes, specify type & how much.	
Other (Describe)	☐ Yes ☐ No		

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	☐		

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	☐	Palpitations	☐	Phlebitis	☐
Productive cough with:	☐	A lot of sputum	☐	Sticky sputum	☐	Clear sputum	
	☐	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:				

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	☐	Recurrent sore throat	☐

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	☐				

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	☐		

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	☐

Sexual and Reproductive Health: *(Check if applicable)*			
Testicular Pain	☐	Sexually Transmitted Disease	☐
Impotence/Erectile Dysfunction	☐	Prostate Problems	☐
Age of First Menses		Years Old	
Duration of Menses (e.g. 3-5 days)		Days	
Length of Cycle (e.g. 28-30 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 and brand:			
Are you pregnant?		☐ **Yes** ☐ **No**	
Have you ever been pregnant?		☐ **Yes** ☐ **No**	
If yes, please indicate:			
Number of Pregnancies		Problems in Pregnancy ☐ Yes ☐ No	
Number of Miscarriages		Problems in Delivery ☐ Yes ☐ No	
Other relevant information			
If you answered yes to having had problems with a pregnancy or delivery, please describe those problems:			

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).

PATIENT CONSENT FORM

I _____ do hereby voluntarily consent to be treated with Acupuncture administered by Acupuncture Student Interns at the MacEwan University Acupuncture Teaching Clinic under supervision of registered Acupuncturists authorized to practice in Alberta.

As the MacEwan University Acupuncture Teaching Clinic is an integral part of the Acupuncture Program, I understand a team, which may include more than one Student Intern, one or more student observers, along with a clinic supervisor, shall be involved in my care. I understand Acupuncture and related modalities involve: the insertion of needles through the skin or, 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 Traditional Chinese Medicine (TCM) utilizes a range of modalities including but not limited to acupuncture, acupressure, moxibustion, cupping, tuina (remedial massage), gua sha (scraping), and infrared heat devices such as TDP heat lamp. I understand any of these modalities may be used in combination during my treatment sessions.

I have been made aware that certain adverse side effects may result. These could include but are not limited to: some local bruising, minor bleeding, fainting, temporary pain or discomfort and temporary aggravation of symptoms.

I understand that in order to provide the student interns with a productive learning experience, it is preferred I receive a minimum of five consecutive treatments by one student intern. I understand that my treatments by a student intern may be limited based on the range of learning opportunities. If a student intern has arrived at a complete understanding of how to treat my condition, another student sntern will be assigned to treat me if I wish to continue with treatments. I understand that the staff of the MacEwan University Acupuncture Teaching Clinic reserve the right to make exceptions to this policy.

I understand the MacEwan University Acupuncture Teaching Clinic **cannot** treat patients with injuries and/or conditions resulting from motor vehicle accidents or workplace accidents where insurance claims or workers compensation claims are involved. I acknowledge the Clinic **cannot** supply reports to third parties such as insurance companies, lawyers or the Workers' Compensation Board.

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.

MacEwan University and its officers, students, employees and agents shall not be liable for any injury, loss or damage sustained or suffered by persons participating in the MacEwan University Acupuncture Teaching Clinic whether caused directly or indirectly by the negligence or fault of MacEwan University, its officers, students, employees, agents or otherwise. The MacEwan University Acupuncture Teaching Clinic staff reserve the right to refuse or discontinue treatment for reasons of appropriateness of a condition to a student learning environment, repeated cancellations or no-shows, harassment of students and/or staff, or disruptive behavior.

I have carefully read and understand all the foregoing and am fully aware of what I am signing. I understand my responsibilities in participating as a patient in the MacEwan University Acupuncture Teaching Clinic.

_____	_____	_____
PATIENT/GUARDIAN NAME **(*Please print)***	**PATIENT/GUARDIAN SIGNATURE**	**DATE** ***(month/day/year)***