Naturopathic – Acupuncture

File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

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General Information

How do you wish to be addressed in our office?

☐ First name ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

How do you wish to be contacted by our office? Email ☐ Phone ☐

Last name:_____ **First name:**_____

Date of birth (D/M/Y):_____

Address:_____

Town/City:_____ **Province:**_____ **Postal Code:**_____

Home Phone: ( )_____ **Cell Phone:** ( )_____

Email:_____ _____ Initial here to consent to email communication from the clinic

How would you describe your gender identity?_____

Gender at birth: ☐ M ☐ F

Occupation:_____

Children: ☐ Y ☐ N **Number and ages of children:**_____

Are you pregnant? ☐ Y ☐ N **How many weeks?**_____

Are you breastfeeding? ☐ Y ☐ N

Medical Dr. Name:_____ **Phone:** ( )_____

Have you had previous acupuncture? ☐ Y ☐ N **With whom?**_____

How did you hear about us?_____

Reason for consulting the office:

☐ I have a specific problem and require help only with this problem.
☐ After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.
☐ After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.
☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well or even better.

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Medical Information

How would you describe your current state of health? (check one)

☐ Excellent ☐ Very Good ☐ Average ☐ Fair ☐ Poor

Please list any current prescription or over the counter medication, including contraceptives/birth control or fertility medications

Medication name	Dosage	Reason	Duration of use

Current Supplements (multivitamins, herbs, vitamins, minerals etc.)

Supp. and brand name	Dosage	Reason	Duration of use

Please list any current or past illnesses, surgeries or conditions, include diagnosis date:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any known or suspected allergies/sensitivities:

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1. _____
2. _____
3. _____

Please list any other therapies or practitioners you are seeing for your health concern (e.g. chiropractor, osteopath, physiotherapist, etc.)

1. _____

2. _____

3. _____

Chief Health Concerns

Please list the reasons, in order of importance, you are seeking acupuncture treatment(s):

1. _____
2. _____
3. _____
4. _____

Family History

Has anyone in your family been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Diabetes	☐ Heart disease	☐ Multiple Sclerosis	☐ Alzheimer's disease
☐ Drug abuse	☐ High blood cholesterol	☐ Osteoporosis	☐ Asthma	☐ Eczema
☐ High blood pressure	☐ Osteoarthritis	☐ Cancer	☐ Epilepsy	☐ Kidney disease
☐ Psoriasis	☐ Depression	☐ Fibromyalgia	☐ Mental illness	☐ Thyroid disorder

Please list any other illnesses of your relatives (parents, siblings, grandparents, aunts, uncles):

_____

_____

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Current Health

Diet and Digestion:

How is your appetite?_____

How many meals do you eat per day? _____ What times do you usually eat? _____

Do you ever have indigestion after eating or stomach pain, discomfort, nausea, vomiting? If so, please describe: _____

Do you eat dairy? ☐ Y ☐ N Do you eat meat? ☐ Y ☐ N

Do you crave flavors?: ☐ Sweet ☐ Salty ☐ Sour ☐ Bitter ☐ Spicy

Were you frequently given antibiotics as a child? ☐ Y ☐ N How often?_____

Do you avoid any foods? If so, please list:_____

Do you have thirst? ☐ Y ☐ N How much liquid do you drink per day?_____

Preference for hot or cold drinks?_____

How are your bowel movements? Do you have: ☐ Diarrhea ☐ Dry stools ☐ Straining

☐ Alternating diarrhea/constipation ☐ Constipation ☐ Loose stools

How many bowel movements do you have per day? _____ What times? _____

Do you have: ☐ Gas ☐ Bloating ☐ Bad Breath

Urination:

How often do you urinate in a day? _____

Do you have: ☐ Profuse Urine ☐ Scanty Urine ☐ Interrupted Flow

Is it difficult to urinate? ☐ Y ☐ N Painful? ☐ Y ☐ N

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If so, please explain:_____

What color is the urine? ☐ Clear ☐ Light yellow ☐ Dark yellow

Do you wake up in the night to urinate? ☐ Y ☐ N If so, how often?_____

Energy:

Do you feel that you have enough energy during the day? ☐ Y ☐ N

What time of day do you have the most energy?_____

What time of day do you have the least energy? _____

Sleep:

How easy is it for you to fall asleep? _____

Do you wake up in the night? ☐ Y ☐ N If so, what wakes you? _____

Do you feel rested in the morning? ☐ Y ☐ N Do you dream? ☐ Y ☐ N

Do you nap during the day? ☐ Y ☐ N What time do you go to bed? _____

What time do you wake up? _____

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Head, Chest, Breathing:

Do you experience any of the following?

☐ Shortness of breath	☐ Vertigo/dizziness	☐ Palpitations
☐ Difficulty breathing	☐ Sinus problems	☐ Chest pain/discomfort
☐ Asthma/wheezing	☐ Phlegm	☐ Chest tightness

Skin and Sweat:

Do you experience any of the following?

☐ Sweat easily	☐ Sweaty hands and feet	☐ Acne or boils
☐ Profuse sweat	☐ Dry skin	☐ Easily bruise
☐ Sweat at night	☐ Rashes	☐ Eczema

Other skin conditions:_____

Temperature:

Do you tend to feel more hot or more cold?_____

Do you experience any of the following:

☐ Cold hands	☐ Cold feet	☐ Other areas cold:
☐ Hot hands	☐ Hot feet	☐ Other areas hot:
☐ Aversion to cold	☐ Aversion to heat	☐ Alternating fever/chills
☐ Chills	☐ Fever	

Emotions:

How would you describe your outlook on life?_____

Which of the following feelings do you resonate with most often?

☐ Anger ☐ Frustration ☐ Sadness ☐ Joy ☐ Worry ☐ Fear ☐ Depression

Is there any emotion that is more difficult for you to feel?_____

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Pain/Tension:

Please describe any pain or tension that you have in your body:

Location	Nature of pain	What makes it better?	What makes it worse?	How long?

Vision:

Do you experience any of the following?

☐ Blurred vision	☐ Poor night vision	☐ Dry eyes
Other:		

Hearing:

Do you experience any of the following?

☐ Ear ringing	☐ Ear aches	☐ Popping
Other:		

Taste:

Do you get particular tastes in your mouth?

☐ Bitter	☐ Metallic	☐ Sweet	☐ Sour

For Women:

Age of first period: _____ Number of pregnancies: _____ Date of late period:_____

Are your menstrual cycles regular? ☐ Y ☐ N Average length of menstrual cycle:_____

How many days does your period last?_____ Is the flow: ☐ Heavy ☐ Light ☐ Normal

What color is the flow? ☐ Bright Red ☐ Pale Red ☐ Dark Red ☐ Purple ☐ Brown

Are there clots? ☐ Y ☐ N If so, what size are the clots: _____

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Which of the following pre-menstrual symptoms do you experience?

☐ Breast tenderness	☐ Water retention	☐ Nausea	☐ Constipation
☐ Breast distension	☐ Headaches	☐ Vomiting	☐ Alternating diarrhea/constipation
☐ Food cravings	☐ Migraines	☐ Diarrhea	☐ Depression
☐ Irritability	☐ Anxiety		

If you experience abdominal cramping, describe the location:_____

When do you experience cramping?_____

Please rate the severity from 1-10 (10 being the most severe):_____

Please describe the nature of cramping:

☐ Stabbing	☐ Better with pressure	☐ Better with heat	☐ Better with exercise
☐ Aching	☐ Worse with pressure	☐ Better with cold	☐ Worse with exercise

Do you have vaginal discharge? ☐ Y ☐ N

Please describe color, viscosity and odor:_____

Do you experience:

☐ Vaginal dryness	☐ Vaginal irritation	☐ Spotting	☐ Vaginal pain
☐ Vaginal itch			

If in menopause, please describe any other symptoms you experience:_____

_____

For Men: Do you experience any of the following?

☐ Swollen testes	☐ Erectile dysfunction	☐ Feeling of cold/numbness in external genitalia
☐ Premature ejaculation	☐ Testicular pain	☐ Other:

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INFORMED CONSENT TO NATUROPATHIC CARE

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors (ND's) assess the whole person by taking into consideration the physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to promote healing. ND's use a variety of therapeutic approaches, either alone, or in combination. These approaches include nutritional and lifestyle counselling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy and physical medicine. Your ND will take a thorough health history, perform screening physical examinations and request laboratory testing when necessary.

It is very important that you inform your ND of any disease you are suffering from, any known allergies you have, and any medications or over-the-counter drugs you are currently taking. Please advise your ND if you are pregnant, suspect you are pregnant, or if you are breastfeeding. As a patient, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the material effects, costs, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight health risks associated with acupuncture. These include but are not limited to:

- Pain, bruising or injury from acupuncture or moxa
- Vasovagal response (feeling faint or dizzy)
- Organ puncture (with deep needling)
- Aggravation of pre-existing symptoms

STATEMENT OF ACKNOWLEDGEMENT

I,_____(please print name) understand that the form of medical care I will be receiving is based on Naturopathic principles and practices. I hereby acknowledge that I have been informed and understand the recommended diagnostic and therapeutic procedure(s)/plan and have discussed them with my ND to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects and I release my ND from any responsibility or side effects. I acknowledge and confirm I have been informed of the diagnostic/therapeutic procedures with respect to potential risks and side effects, expected benefits, financial costs and the likely consequences of not having/following the provided recommendations and what alternative course(s) of action are available to me. I understand that this record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. If seeing more than one practitioner at Waterdown Village Chiropractic and Wellness Group, I imply consent for them to share and discuss my file as deemed necessary by the practitioners to ensure that I receive the most appropriate care for my condition.

I also acknowledge that:

1. Any treatment or advice provided to me as a patient of Naturopathic Medicine is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider.
2. I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider qualified to practice in Ontario.
3. My ND has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider.
4. The treatment and therapies rendered or recommended by my ND may be different from those usually offered by a medical doctor or other licensed health care provider.
5. I acknowledge that full payment is required at the time services are provided or supplements are purchased.

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I declare that my ND has explained to the best of her ability, the treatment or services that I may receive and hereby authorize and consent to treatment. I intend this consent to apply to all my present and future naturopathic treatments.
Patient Name (print):_____ Date:_____

Signature:_____

Parent/Guardian signature (if under 16 years old):_____

CANCELLATION POLICY

While the clinic does provide regular appointment reminders, I acknowledge that I am responsible for my attendance and that 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, or if I fail to show for my scheduled appointment, I understand that one of the following charges will be applied to my account:

- A **cancellation fee of $25.00** should I cancel an appointment with less than 24 hours' notice
- A **full appointment fee** should I not show for my scheduled appointment without notice

Please initial to confirm that you have read the cancellation policy and agree to pay any outstanding balances owing._____ **(Initial here)**