

HEAD TO TOE HEALTH CENTRE  
**TCM Intake Form**



*This confidential information of your medical record and health history will be kept in the Head to Toe Health Centre and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your health care outcomes.*

**Contact Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F  
Address: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_  
Occupation: \_\_\_\_\_ Country of Origin: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
How did you hear about the Head to Toe Health Centre? \_\_\_\_\_

**Email/  
E-newsletter:**

Email Address: \_\_\_\_\_

Would you like to receive our e-newsletter\* to this email?  Yes  No

\*Periodically Head to Toe sends out an e-newsletter updating patients on clinic news and events providing helpful holistic health care information. Your email address will not be shared.

**Health Goals/Concerns:**

What main health goal/concern brought you to the clinic today? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition: \_\_\_\_\_

Previous practitioners consulted for this condition:  MD  ND  Other \_\_\_\_\_

Please explain their diagnosis, therapy and results where applicable: \_\_\_\_\_

What types of therapy have you tried for this problem?

- Diet modification     Vitamin/mineral supplements     Herbs     Homeopathy     Chiropractor  
 Acupuncture     Conventional drugs     Other \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Please list any other health concerns or goals in order of importance: \_\_\_\_\_

# Medical History:

How would you describe your general state of health:  Excellent  Good  Fair  Poor

For the following tables, please use the back of this page if more room is required:

**Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:**

Hospitalization, Surgery, Injury	Date	Symptoms	Condition Resolved?

**Allergies and/or food sensitivities:**

Allergy/Sensitivity	Symptoms	Treatment/Avoidance?

**Current medications/supplements: Please list ALL medications or supplements you take on a regular basis:**

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner	Are You Taking Presently?

# Family History:

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

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> High Blood Cholesterol	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Depression	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Thyroid Disorder

Please list any other illnesses of your relatives, such as parents siblings, grandparents, aunts and uncles:

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## Diet & 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? \_\_\_\_\_

How is your appetite? \_\_\_\_\_

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:

<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dry Stools	<input type="checkbox"/> Alternating Diarrhea/Constipation
<input type="checkbox"/> Constipation	<input type="checkbox"/> Loose Stools	<input type="checkbox"/> Straining

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

Do you have:  Bitter Gas  Bitter Bloating  Bitter 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 If so, please explain: \_\_\_\_\_

What colour 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? \_\_\_\_\_

## Head, Chest and Breathing:

Do you experience any of the following?

<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Vertigo/Dizziness	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Chest Pain/Discomfort
<input type="checkbox"/> Asthma/Weezing	<input type="checkbox"/> Phlegm (please describe) _____	<input type="checkbox"/> Chest Tightness

## Skin/Sweat:

Do you experience any of the following?

<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Sweaty hands and feet	<input type="checkbox"/> Acne or Boils
<input type="checkbox"/> Profuse sweat	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Easily bruised
<input type="checkbox"/> Sweat at night	<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema
<input type="checkbox"/> Other skin condition: _____		

Does your sweat have an odor?  Y  N If so, please describe: \_\_\_\_\_

## Temperature:

Do you tend to feel more hot or more cold? \_\_\_\_\_

Do you experience any of the following?

<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Other areas cold: _____
<input type="checkbox"/> Hot hands	<input type="checkbox"/> Hot feet	<input type="checkbox"/> Other areas hot: _____
<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Alternating fever and chills
<input type="checkbox"/> Aversion to cold	<input type="checkbox"/> Aversion to heat	

## Emotions:

How would you describe your outlook on life lately? \_\_\_\_\_

Do any of the following feelings occur more frequently:  Anger  Frustration  Sadness  Joy  Worry  Fear  Depression

Is there an emotion that is more difficult for you to feel? \_\_\_\_\_

## 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?

<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Poor night vision	<input type="checkbox"/> Dry eyes
<input type="checkbox"/> Other eye condition: _____		

## Hearing:

Do you experience any of the following?

<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Popping
<input type="checkbox"/> Other ear condition: _____		

## Taste:

Do you ever get a particular taste in your mouth?

<input type="checkbox"/> Bitter	<input type="checkbox"/> Metallic	<input type="checkbox"/> Sweet	<input type="checkbox"/> Sour
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## For Women:

Age of first period: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

Is your menstrual cycle regular?  Y  N Average days of entire cycle: \_\_\_\_\_

## For Women (cont.):

How many days does your period last? \_\_\_\_\_ Is the flow:  Heavy  Light  Normal

What colour is the flow?  Bright Red  Pale Red  Dark Red  Purple  Brown

Are there clots?  Y  N If so, what colour are the clots? \_\_\_\_\_ What size are the clots: \_\_\_\_\_

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

<input type="checkbox"/> Breast Distension	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Alternating Diarrhea/Constipation
<input type="checkbox"/> Food Cravings	<input type="checkbox"/> Migraines	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression
<input type="checkbox"/> Irritability	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other emotions: _____	
<input type="checkbox"/> Abdominal cramps (If so, please describe where you feel the pain): _____			

Please describe nature of cramping:

<input type="checkbox"/> Stabbing	<input type="checkbox"/> Better with pressure	<input type="checkbox"/> Better with heat	<input type="checkbox"/> Better with exercise
<input type="checkbox"/> Aching	<input type="checkbox"/> Worse with pressure	<input type="checkbox"/> Better with cold	<input type="checkbox"/> Worse with exercise

Do you have vaginal discharge?  Y  N Describe colour, viscosity and odor of discharge: \_\_\_\_\_

Do you experience:

<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Vaginal irritation	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Vaginal pain	<input type="checkbox"/> Vaginal itch	

Age of last period: \_\_\_\_\_ Please describe symptoms related to menopause: \_\_\_\_\_

## For Men:

Do you experience:

<input type="checkbox"/> Swollen testes	<input type="checkbox"/> Impotence	<input type="checkbox"/> Feeling of coldness or numbness in external genitalia
<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Other: _____

## Other:

Is there anything else that you feel is important that hasn't been addressed on this form? \_\_\_\_\_

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

# Patient Agreement Form Traditional Chinese Medicine & Acupuncture



Your signature below acknowledges the following:

1. *I understand that Traditional Chinese Medicine & Acupuncture is not covered by the provincial government (OHIP), though may be covered by private and extended insurance plans. Traditional Chinese Medicine & Acupuncture may also be tax deductible.*
2. *The fees and services have been clarified in advance. Payment is due at the end of each visit as the Head to Toe Health Centre does not bill insurance companies directly. Cash, Cheque, Interac, Visa, and Mastercard are acceptable methods of payment.*
3. *Twenty-four hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment fee.*
4. *Items purchased are non-refundable, whether or not they have been opened.*
5. *I recognize that Traditional Chinese Medicine & Acupuncture is not an isolated system of care and that practitioners welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.*

## Informed Consent:

As a patient of the Head to Toe Health Centre, I hereby acknowledge that I am willing to provide my practitioner with the information necessary for them to fully understand my medical history, presenting symptoms, and the health goals I wish to achieve in our work together. I thereby consent to a thorough case history and TCM diagnosis.

I understand that the Head to Toe Health Centre will keep a record of my personal health information and of the services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. I understand that the Head to Toe Health Centre will act as the Health Information Custodian for my personal and health information. If I am seeing more than one practitioner at the Head to Toe Health Centre, I imply consent for them to share and discuss my file as deemed necessary by the practitioners, to ensure that I receive care most appropriate for my condition.

I understand that Traditional Chinese Medicine & Acupuncture can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that one method of treatment need not be chosen over others and that various methods often work best in conjunction with one another.

I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Traditional Chinese Medicine & Acupuncture include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to herbs or interactions with prescription medications, and pain, bruising, fainting or injury from acupuncture or moxa.

As with all forms of therapy, I understand that Traditional Chinese Medicine & Acupuncture also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect my practitioner at the Head to Toe Health Centre to be able to anticipate and explain all risks and complications prior to treatment.

With this knowledge, I voluntarily consent to Traditional Chinese Medicine & Acupuncture and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient name (Please print): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_