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:_____Email: _____

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:

Would you like to receive our e-newsletter* to the email address provided?
☐ 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?

☐ Alcoholism	☐ Diabetes	☐ Heart Disease	☐ Multiple Sclerosis
☐ Alzeimer'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, such as parents siblings, grandparents, aunts and uncles:

_____

_____

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? _____

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	☐ Alternating Diarrhea/Constipation
☐ Constipation	☐ Loose Stools	☐ Straining

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 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?

☐ Shortness of Breath	☐ Vertigo/Dizziness	☐ Palpitations
☐ Difficulty Breathing	☐ Sinus Problems	☐ Chest Pain/Discomfort
☐ Asthma/Weezing	☐ Phlegm (please describe) _____	☐ Chest Tightness

Skin/Sweat:

Do you experience any of the following?

☐ Sweat easily	☐ Sweaty hands and feet	☐ Acne or Boils
☐ Profuse sweat	☐ Dry skin	☐ Easily bruised
☐ Sweat at night	☐ Rashes	☐ Eczema
☐ 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?

☐ Cold hands	☐ Cold feet	☐ Other areas cold: _____
☐ Hot hands	☐ Hot feet	☐ Other areas hot: _____
☐ Fever	☐ Chills	☐ Alternating fever and chills
☐ Aversion to cold	☐ 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?

☐ Blurred vision	☐ Poor night vision	☐ Dry eyes
☐ Other eye condition: _____		

Hearing:

Do you experience any of the following?

☐ Ear ringing	☐ Ear aches	☐ Popping
☐ Other ear condition: _____		

Taste:

Do you ever get a particular taste in your mouth?

☐ Bitter	☐ Metalllic	☐ Sweet	☐ Sour

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?

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

Please describe 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 Describe colour, viscosity and odor of discharge: _____

_____

Do you experience:

☐ Vaginal dryness	☐ Vaginal irritation	☐ Bleeding between periods
☐ Vaginal pain	☐ Vaginal itch	

Age of last period: _____ Please describe symptoms related to menopause: _____

_____

For Men:

Do you experience:

☐ Swollen testes	☐ Impotence	☐ Feeling of coldness or numbness in external genatalia
☐ Testicular pain	☐ Premature ejaculation	☐ Other: _____

Other:

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

_____

_____

HEAD TO TOE HEALTH CENTRE

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 gouvernment (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: _____