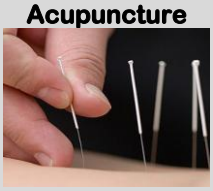
TCM CLINEEK-Etobicoke

YIN & YANG BALANCE

Acupuncture



Cosmetic Acupuncture

Chinese Herbal Medicine

Guided Meditation

BodyTalk Access

Patient Intake Form

Last Name:	First Name:	Sex:
Address:		Date of Birth:
City/Province:	Postal Code:	Date of 1st visit:
Cell Phone Number:	E-mail:	Home Phone Number:
Work Phone Number:	Occupation:	Marital Status:
Emergency Contact's Name:	Relationship:	Phone Number:
Family Physician:	Phone Number:	How did you hear about us?

General Health Condition of Patient

Major Medical + Mental Health conditions: Please circle which ever applies to you. **Other Medical Conditions; please specify:**	AIDS, Asthma, Arthritis, Cancer, Alcoholism, Diabetes Type I, Diabetes Type II, Easily Bruising, Hemophilia, High Blood Pressure, Heart Disease, Hepatitis B, Hepatitis C, HIV+, Hypo/Hyper Thyroidism, Pace Makers, Psychological Disorders, Seizures, Significant Trauma, Surgeries
Chief Complaint & Duration	
Medications & Natural Remedies	
Diet (Please describe briefly)	
Environmental or Food & Drug Allergies	
Patient's Past History of Illnesses	
Family History of Illnesses	

Note: This is a 3 page intake form. Please check boxes that apply to you on back page (page 2), and sign the 3rd page.

Your Life Style

☐ Alcohol ☐ Marijuana ☐ Stress ☐ Exercise
☐ Tobacco ☐ Drugs ☐ Occupational Hazards Frequency: _____

General Symptoms

☐ Poor Appetite ☐ Poor Sleep ☐ Bodily Heaviness ☐ Chills, feeling cold ☐ Fever, feeling warm
☐ Heavy Appetite ☐ Heavy Sleep ☐ Cold Hands/feet ☐ Night Sweating ☐ Bleeding/bruising
☐ Cold drink preference ☐ Dreaming ☐ Poor Circulation ☐ Sweating Easily ☐ Odd Taste, Describe:
☐ Hot drink preference ☐ Fatigue ☐ Breath Shortness ☐ Muscle Cramps _____
☐ Weight Gain/Loss ☐ Lack of Strength ☐ Vertigo ☐ Dizziness _____

Head, Eyes, Ears, Nose, Throat

☐ Glasses ☐ Night Blindness ☐ Lips/Tongue Sores ☐ Repeat Sore Throat ☐ Headaches
☐ Eye Strain ☐ Glaucoma ☐ Dry Mouth ☐ Swollen Glands ☐ Migraines
☐ Eye Pain ☐ Cataracts ☐ Excessive Saliva ☐ Lumps in Throat ☐ Concussions
☐ Red Eyes ☐ Teeth Problems ☐ Sinus Problems ☐ Enlarged Thyroid ☐ Head/neck symptoms:
☐ Itchy Eyes ☐ Grinding Teeth ☐ Excessive Phlegm ☐ Nose Bleeding _____
☐ Spots in Eyes ☐ TMJ ☐ Color of Phlem ☐ Ringing in Ear _____
☐ Poor Vision ☐ Facial Pain ☐ Poor Hearing _____
☐ Blurred Vision ☐ Gum Problems ☐ Earaches _____

Respiratory

☐ Difficult Breathing ☐ Chest Tightness ☐ Wet Cough ☐ Coughing Blood ☐ Color of Phlegm
☐ Breath Shortness ☐ Asthma ☐ Dry Cough ☐ Pneumonia _____

Cardiovascular

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Tachycardia ☐ Phlebitis
☐ Blood Clots ☐ Fainting ☐ Difficulty Breathing ☐ Heart Palpitations ☐ Irregular Heartbeat

Gastrointestinal

☐ Nausea ☐ Diarrhea ☐ Intestinal Cramps ☐ # of Bowel Movements/Day
☐ Vomiting ☐ Constipation ☐ Itchy Anus ☐ Color: ☐ Odor:
☐ Acid Regurgitation ☐ Laxative Usage ☐ Burning Anus Texture: Form:
☐ Gas ☐ Black Stools ☐ Rectal Pain ☐ Hiccup ☐ Bad Breath
☐ Bloating ☐ Bloody Stool ☐ Hemorrhoids ☐ Mucous in Stool ☐ Anal Fissures

Musculoskeletal

☐ Neck/Shoulder Pain ☐ Upper Back Pain ☐ Joint Pain ☐ Limited Motion Range Other, Describe:
☐ Muscle Pain ☐ Low Back Pain ☐ Rib Pain ☐ Limited Use _____

Skin and Hair

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Change in hair/skin texture:
☐ Hives ☐ Psoriasis ☐ Itching ☐ Fungal Infections
☐ Ulcerations ☐ Acne ☐ Hair Loss ☐ Other Skin/hair Problems:

Neuropsychological

☐ Seizures ☐ Poor Memory ☐ Irritability ☐ Considered Suicide ☐ Tics
☐ Numbness ☐ Depression ☐ Easily Stressed ☐ Abuse Survivor ☐ Anxiety

Genito-urinary

☐ Pain in Urination ☐ Blood in Urine ☐ Veneral Disease ☐ Increased Libido ☐ Impotence
☐ Frequent Urination ☐ Unable to Hold Urine ☐ Bed Wetting ☐ Decreased Libido ☐ Premature Ejaculation
☐ Urgent Urination ☐ Incomplete Urination ☐ Wake to Urinate ☐ Kidney Stone ☐ Nocturnal Emission

Gynecology

☐ Age Menses Began ☐ Duration of Flow ☐ Vaginal Discharge ☐ Breast Lumps Date of last PAP:
☐ Menstruation Length ☐ Irregular Periods ☐ Vaginal Sores ☐ # of Pregnancies _____
☐ Cycle Length(day 1-day 1) ☐ Painful Periods ☐ Vaginal Odor ☐ # of Live Births Date Last Period Began:
☐ Mood Swing ☐ PMS ☐ Clots ☐ Premature Births Menopause Age: _____

Other Gynecological Problems:

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Informed Consent for Acupuncture, TCM, and Reiki treatment

I hereby request and consent to the performing of acupuncture (traditional or cosmetic) and other procedures as necessary including, electrical acupuncture, ear acupuncture, ear seeding, Chinese herbal medicine, nutritional and supplement therapy , Reiki energy healing (Guided meditation) and Bodytalk Access, by Mort Neek Registered TCM Practitioner, Acupuncturist, Nutritional Consultant & Reiki Master).

I understand and am informed that there are some risks to treatment including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting.
I have been advised that **only pre-sterilized** needles will be used.

I wish to rely on the practitioner's judgment during the course of the treatment, based upon the facts then known, in my best interests. I understand that the results are not guaranteed.

Please note that acupuncture and herbal medicine are safe. Occasional bleeding or bruising or post needling sensation may happen. Fainting may occur for new patients due to nervousness, hunger or extreme tiredness. Chinese herbs are also very safe and effective. Occasional abdominal upset, diarrhea, insomnia and sweating may happen, although this can be the body's response to treatment.

Female Patients:
I understand that if I am pregnant, or trying to become pregnant, I must notify the practitioner to modify the treatment plan, to avoid fetal distress.

Cosmetic Acupuncture Recipients:
I fully understand that I need to follow the recommended course of treatment (which is 12 treatments in a row, once a week and consecutive monthly treatments for maintenance), to achieve and maintain desirable results. I also acknowledge that there is a chance of bruising with the procedure as with regular body acupuncture.

Reiki Treatment Recipients:
I understand that REIKI is administered by laying hands on patient's body. During Reiki treatment energy may vibrate practitioner's body and hands, which will be transferred to patient's body. This is not a massage by any means.

I have read the consent form and had the opportunity to ask questions about the content. By signing below, I agree to the above mentioned TCM procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment. I also give my consent to receive monthly newsletters about acupuncture, by e-mail.

Cancellation Policy:
I understand that I need to notify the clinic of any cancellations or changes at least 24 hrs in advance, or a cancellation fee equal to the full amount of the treatment fee will be applied.

Consent:

I (the undersigned) hereby request and consent to receive Traditional Chinese Medicine treatments (Acupuncture, Herbal Medicine, Nutritional Therapy, Reiki and other aforementioned modalities), and acknowledge that the treatments and their ramifications have been fully explained to me.

Please read before signing.

_____ _____
Signature of Patient Date