Muscle & Joint Clinic

Acupuncture Intake Form

Name (first)_____ (last) _____

Date of Birth (dd/mm/yy)_____/_____/_____ Age: _____ Height: _____ Weight: _____(lbs)

Gender: ☐ M ☐ F Occupation:_____

Address: _____ City: _____

Postal Code: _____ Home Ph: _____ Work Ph: _____

Email: _____ How Did You Hear About Us? _____

Do you have extended health insurance? ☐ Yes ☐ No If Yes please indicate below:

☐ Great West Life ☐ Blue Cross ☐ Desjardins ☐ Sunlife ☐ Greensheild ☐ Manulife ☐ Other

Other: _____ Policy Number _____ Group ID _____

Consultation (10 min)..... Free	Acupuncture Treatment.....$60*
Acupuncture Examination.....$30*	Documentation .....$20* pp

*HST Applicable

Clinic Fees & Policies

- All fees are due at time of service and It is the patient's or guardian's responsibility to ensure the clinic is fully compensated for all services rendered.
- A 48-hour cancellation policy is in effect. Failure to show up for a scheduled appointment or arriving 30 minutes late will result in a no show fee of half of the visit fee will be added to the patient's account.
- Accounts over ninety days may be subject to collections and a twenty-five percent service fee.
- All insurance related information collected by our clinic can not be guaranteed to be accurate. Please contract your insurance company directly for accurate information in regards to your insurance plan.

If you have read and agree to the clinic fees and policies above please sign below:

(Please Sign Here) _____

4-5980 Churchill Meadows Blvd, Mississauga L5M 7M5

Do You Have A Significant Illnesses:

☐ AIDS, ☐ Cancer, ☐ Diabetes, ☐ Haemophilia, ☐ Heart Disease, ☐ Hepatitis (type_____), ☐ HIV (+), ☐ Seizures, ☐ Recent Significant Trauma (auto accident, falls etc), ☐ Fractures, ☐ Tuberculosis, ☐ Other types of communicable diseases (if any, please specify): _____

Primary Health Concern:

Purpose of visit: ☐ Consultation only ☐Consultation with Treatment ☐Acupuncture ☐Herbal Medicine

How did you hear about us?

Please List Any Medication You Are Taking		Please List Any Surgeries You Have Had
Name	Reason	

Your Lifestyle

□Alcohol	□Marijuana	□Stress	□Regular Exercises	
□Tobacco	□Drugs	□Occupational Hazards	Type _____	Frequency _____

General Symptoms

□Poor appetite	□Poor sleep	□Bodily heaviness	□Chills	□Bleed or bruise easily
□Heavy appetite	□Heavy sleep	□Cold hands or feet	□Night sweat	□Peculiar taste
□Prefer cold drinks	□Dream-disturbed sleep	□Poor circulation	□Sweat easily	
□Prefer hot drinks	□Fatigue	□Shortness of breath	□Muscle cramps	
□Weight fluctuation	□Lack of strength	□Fever	□Vertigo / dizziness	

Head, Eyes, Ears, Nose, Throat

□Glasses	□Night blindness	□Sores on lips or tongue	□Recurrent sore throat	□Headaches
□Eye strain	□Glaucoma	□Dry mouth	□Swollen Glands	□Migraines
□Eye Pain	□Cataracts	□Excessive saliva	□Lumps in throat	□Concussions
□Red eyes	□Teeth Problem	□Sinus problems	□Enlarged thyroid	□Other head pain
□Itchy eyes	□Grinding Teeth	□Excessive phlegm	□Nose bleeds	□Other neck pain
□Spots in eyes	□TMJ	Color of phlegm _____	□Ringing in ears	
□Poor vision	□Facial pain	□Loss of taste	□Poor hearing	
□Blurred vision	□Gum problems	□Loss of smell	□Ear aches	

Respiratory

□Shortness of breath	□Tight chest	□Cough	□Color phlegm	□Coughing blood
□Difficulty Breathing if lying down	□Asthma / wheezing	Wet or Dry? _____	_____	□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 pain / cramps	Bowel movement:	□Hard stool
□Vomiting	□Constipation	□Itchy anus	Frequency_____	□ Loose stool
□Acid regurgitation	□Laxative use	□Burning anus	Color_____	□ Strong Odour
□Gas	□Black stools	□Rectal pain		□ Undigested food
□Hiccup	□Bloody stools	□Haemorrhoid		
□Bloating	□Mucous in stools	□Anal fissures		
□Bad breath				

Musculoskeletal

□Neck / Shoulder pain	□Upper back pain	□Joint pain / stiffness	□Limited Range of Motion	□Other (describe) _____
□body pain (sides)	□Lower back pain	□Rib Pain	□Limited use	

Skin, Nail and Hair

□Rashes	□Eczema	□Dandruff	□Hair texture changes	□Other hair / skin issues
□Hives	□Psoriasis	□Itching skin / scalp	□Skin texture changes	□Fungal infections
□Ulcerations	□Acne	□Hair loss	□Skin color changes	□Nail problems

Neuropsychological

□Seizures	□Poor memory	□Irritability	□suicidal	Other (specify) _____
□Numbness	□Depression	□Easily stressed		
□Tics	□Anxiety	□Abuse survivor	□Seeing a therapist	

Genito-urinary

□Painful urination	□Blood in urine	□Venereal disease	□Increased libido	□Impotence
□Frequent urination	□Unable to hold urine	□Bedwetting	□Decreased libido	□Premature ejaculation
□Urgent urination	□Incomplete urination	□Wake to urinate	□Kidney stone	□Nocturnal emission

Gynaecology

Age menses began ____	Duration of flow ____	□Vaginal discharge	□Breast lumps	Date of last PAP
Length of cycles _____	□Irregular periods	□Vaginal sores	# Pregnancies _____	_____
Clots (color) _____	□Painful period	□Vaginal odour	# Live births_____	Last menses date_____
	□PMS		Age at menopause____	

YOUR PRIVACY IS OUR PRIORITY

Patient Consent Form For Collection, Use and Disclosure of Personal Information

In this office, for their respective patients, Dr. Faisal Malik acts as the Privacy Information Officer. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate use and protection of your information. Attached to this consent form, we have outlined what our office is doing to ensure that: Only necessary information is collected about you; Information is shared only with your consent; Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols; Our privacy protocols comply not only with privacy legislation, but with the standards of the Ontario Chiropractic Association, and the law. Do not hesitate to discuss our policies with Dr. Faisal Malik or any member of our office staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality health care. This office will collect, use and disclose information about you for the following purposes: To offer and provide treatment, care and services for all chiropractic health care issues. To deliver safe and efficient patient health care and to identify and ensure continuous high quality service. To assess your health care needs and to advise you of treatment options. To enable us to contact you and maintain communication with you, for purposes of distributing health care information and booking/confirming appointments for treatments. To invoice for goods and services, to process credit card payments, and to collect on unpaid accounts. To communicate with other treating health care providers, including your pharmacist/pharmacy. To communicate with laboratories in cases where laboratory services are required. For teaching and demonstrating purposes on an anonymous basis. To complete and submit chiropractic claims for third party adjudication and payment. To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Ontario Chiropractic Association in a timely fashion, when required, according to the provisions of the Personal Health Information Protection Act (PHIPA) . To comply with agreements/undertakings entered into voluntarily by the member with the Ontario Chiropractic Association, including the delivery and/or review of patients' charts and records to the Association in a timely fashion for regulatory and monitoring purposes. To deliver your charts and records to the Chiropractic insurance carrier to enable the insurance company to assess liability and quantify damages, if any. To assist this office to comply with all regulatory requirements and to comply generally with the law By signing the consent section of the Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the Personal Health Information Protection Act (PHIPA) for the purposes of the Ontario Chiropractic Association fulfilling its mandate under the PHIPA, and for the defense of a legal issue. Our office will not, under any condition, supply your insurer with your confidential medical history. In the event that this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information at any time, and we will explain the ramifications of the decision, and the process.

Patient Consent

I have reviewed the Privacy Policy that explains how this office will use my personal information, and the steps this office is taking to protect my information. I know that this office has a Privacy Policy, and I can ask to see the Policy at any time. I agree that Dr. Faisal Malik and his staff can collect, use and disclose personal information about myself as set out in the attached information about the office's privacy policies.

Signature: _____ Date (dd/mm/yy): _____/_____ /_____

Acupuncture Treatment Consent Form

1. Acupuncture / Chinese Herbal Medicine and other Traditional Chinese Medicine (TCM) modalities are safe and effective for the prevention and treatment of a wide range of health problems, and for the promotion of general well being. Although Acupuncture / TCM are helpful for many health conditions, it is not intended to replace any tests or treatments recommended by your physicians. Please continue your medications prescribed by your physician while you receive TCM Services at this clinic.

2. Acupuncture / TCM services are not covered by OHIP. Coverage is provided by some extended healthcare plans, please check with your employee benefits. The initial consultation (within 15 minutes) is free. If a detailed assessment is required, which exceeds 15 minutes, cost for the consultation is: $30.

3. Please note that Acupuncture is safe. Occasional bruising, and post needling sensation may occur. Fainting may occur due to nervousness, hunger or extreme tiredness.

4. Chinese herbs are also very safe and effective. Occasional abdominal upset, diarrhea and sweating may occur in response to treatment. If you have any concerns please do not hesitate to ask.

Consent to Treatment:

I _____ (undersigned patient) hereby request and consent to receive Traditional Chinese Medical treatments including acupuncture, herbal medicine and other related treatment from the practitioners at Canadian Muscle & Joint Pain Clinic. I acknowledge that the above treatments and their risks, benefits and side effects have been fully explained to me.

_____	_____	_____
Name of Patient	Signature of Patient	Date
_____	_____	_____
Name of Registered Acupuncturist	Signature of Registered Acupuncturist	Date

Chief Complaint and Duration:

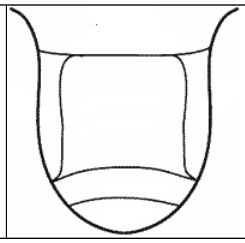
History of the present illness:

- Onset:
- Characteristics:
- Accompany symptoms:
- Relieving / Exacerbating factors:
- Tests:
- Treatment (result?):

General Information:

- Chills/Fever:
- Sweating:
- Appetite and Thirst:
- Urine / Stool:
- Head:
- Body:
- Chest:
- Abdomen:
- Arms and Legs:
- Eyes:
- Ears:
- Nose:
- Throat:
- Sleep:
- Emotion:
- Energy:

- Female Disorders:
- Diet / Stress:
- Past medical history:
- Past family medical history:
- General Appearances (spirit, speech, body shape and movement):

Tongue: (body color, shape, cracks, movements and coating: color, moist, thickness, peeled, greasy, ulcers) **Listening and Smelling**	

Pulse: (location, strength, rate and quality)

	Cun	Guan	Chi
Left			
Right			

Summary of Main Symptoms and Signs:

TCM Disease Diagnosis:

TCM Syndrome Differentiation:

Treatment Principles:

Treatment Remedies: (Acupuncture, herbs, others)