



Please help us provide you with a complete evaluation by taking the time to fill out this intake form carefully. All of your answers will be held completely confidential. If you have any questions, please ask. Thank you.

NAME: _____ **DATE:** _____

ADDRESS: _____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

DATE OF BIRTH (DD/MM/YYYY): _____ **AGE:** _____ **SEX:** _____

EMAIL: _____ **Would you like to be added to our newsletter?** _____

PHONE HOME: _____ **WORK:** _____ **CELL:** _____

MAY WE LEAVE MESSAGES RELATING TO YOUR VISIT? _____

EMERGENCY CONTACT INFO:

NAME / RELATION: _____ **PH#:** _____

OTHER HEALTH CARE PROVIDERS YOU ARE CURRENTLY SEEING

NAME: _____ **PH#:** _____ **SPECIALTY:** _____

NAME: _____ **PH#:** _____ **SPECIALTY:** _____

May we contact your physician(s) about your condition/treatment? _____

PLEASE LIST / DESCRIBE YOUR CHIEF CONCERNS (in order of priority):

- 1
- 2
- 3
- 4
- 5

Have you been treated by anyone else for these concerns? If so, when, how and did it help? _____



HOW DID YOU HEAR ABOUT OUR CLINIC?

DO YOU HAVE ANY ALLERGIES (MEDICATIONS, SEASONAL, ENVIRONMENTAL, FOOD)?

ALLERGY	REACTION

PLEASE LIST ANY CURRENT MEDICATIONS OR SUPPLEMENTS INCLUDING DOSE:

MEDICATION	DOSE

MEDICAL HISTORY

PLEASE LIST ANY PAST MEDICAL CONCERNS (eg: illnesses, injuries, hospitalizations, surgeries, traumas):

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please select if applies)

- | | | |
|-------------|---------------------|-------------------------|
| Abortion | Gonorrhea | Mumps |
| Allergies | Hearing Loss | Parasites |
| Anemia | Heart Disease | Pneumonia |
| Angina | Hepatitis | Pregnancy |
| Arthritis | Hernia | Psoriasis |
| Asthma | Herpes | Rubella |
| Abuse | High Blood Pressure | Scarlet Fever |
| Bronchitis | HIV/AIDS | Strep Throat |
| Cancer | Irritable Bowel | Syphilis |
| Cataracts | Jaundice | Thyroid problems |
| Chicken Pox | Kidney Disease | Tinnitus |
| Crohn's | Kidney Stones | Tuberculosis |
| Cirrhosis | Leukemia | Ulcerative Colitis |
| Deafness | Lupus | Ulcers |
| Diabetes | Measles | Urinary Tract infection |
| Eczema | Menstrual disorder | Whooping Cough |
| Emphysema | Miscarriage | Yeast Infection |
| Gallstones | Mononucleosis | Other: |



PLEASE LIST ANY DIAGNOSTIC TESTS (X-RAYS, BLOOD TESTS ETC) YOU'VE HAD FOR THESE CONCERNS?

PLEASE CHECK ALL OF THE FOLLOWING THAT ARE PRESENT IN YOUR FAMILY HISTORY AND THE RELATION

Arthritis
Allergies
Cancer
Diabetes
Heart Disease

High Blood Pressure
Stroke Or Blood Clots
Depression/Anxiety
Mental Illness
Dementia/Alzheimer's

Addiction/Alcoholism
Kidney Disease
Asthma
Skin Disorder
Other



INFORMED CONSENT TO TRADITIONAL CHINESE MEDICINE/ACUPUNCTURE TREATMENT

Shawna Clark, R.TCMP, R.Ac utilizes the principles and practices of TCM, case history, other supportive therapies and functional tests to assess and assist the body's own ability to heal and to improve the quality of life and health through natural means. All of the information gathered will be maintained with complete confidentiality and any personal information will not be shared without first gaining my consent, with the exception of professional consult or dialogue with regards to specific patient care.

The slight health risks of some TCM treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, drowsiness, bruising, bleeding or injury from acupuncture. As a patient of this clinic, I have read and understand this information, and I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions. The information provided is complete and inclusive of all past and present health concerns including risk of pregnancy and all medications, over the counter drugs and supplements. I agree to immediately inform the attending TCM practitioner of any adverse effects I may experience, any disease process that develops during treatment, any medications or drugs, over the counter or otherwise, that I use or change, or if I become pregnant, suspect pregnancy or are breast-feeding. Accepting treatment further implies compliance with treatments to the best of my ability and to inform the attending TCM practitioner of any non-compliance, intended or otherwise. I understand that treatment results for each individual are variable and TRADITIONS CLINIC and Shawna Clark, R.TCMP, R.Ac do not and cannot predict or guarantee individual treatment results at any time.

I also confirm that I have the ability to accept or reject this care of my own free will. I acknowledge that I have a right to purchase remedies and vitamins from a source other than what is available from Shawna Clark, R.TCMP, R.Ac. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.

ACUPUNCTURE TREATMENTS

Only single use, sterile & disposable needles are used in this clinic.

Apart from general medical information, it is important that you let your practitioner know:

- | | | |
|--|---|---|
| • If you have a history of fainting spells | Y | N |
| • If you have a pacemaker or any other electrical implants | Y | N |
| • If you have a bleeding disorder | Y | N |
| • If you are taking anti-coagulants (blood thinners) | Y | N |
| • If you are or are planning to become pregnant | Y | N |

I acknowledge that the treatments are not covered by OHIP and I accept full responsibility for any fees incurred during care and treatment at the time of my visit. Telephone consultations will be billed to me according to the length of time. Cancellations must be made 48 hours prior to my scheduled appointment time to avoid being charged a cancellation fee. (initial)

Patient Name (please print):

Signature of Patient or Guardian: _____ Date: _____



Dear Valued Patient,

TRADITIONS CLINIC is an established, reputable and busy inter-disciplinary wellness clinic. We maintain a deep respect and appreciation for our clientele and do our utmost to fulfill your expectations and help you meet your health goals. Our practitioners' time is in high demand and we ask that our valued patients respect all appointment times that have been allotted for you.

Our cancellation policy has evolved to reinforce the mutual respect required between practitioners and patients to provide the high quality service we strive for. In order to keep things running smoothly and efficiently, to allow for equal access to care for all of our patients and to encourage compliance and success, our cancellation policy must be universally applied and deferred to.

TRADITIONS CLINIC requires 48 hours notice for all cancellations. Appointments cancelled or missed within 48 hours of the set appointment will be charged a fee. The fee is set at half the rate of the scheduled time and will be processed 48 hours after that set time. Emergencies are exempt from this policy and patients are given this 48-hour period to explain their absence. We appreciate your understanding and cooperation.

As a patient at TRADITIONS CLINIC, I recognize the above mentioned cancellation policy and authorize an automatic charge and payment for any missed appointments or appointments cancelled within the 48 hour period prior to my scheduled appointment, exempting notification of emergencies within 48 hours after my scheduled appointment.

Name

Signature _____

Date

Credit card #

VISA

MC

Expiry date

(MM/YR)

security code