

New Patient Intake Form



Please complete the following three pages, so we can best meet your health care needs.
If you have any questions, please do not hesitate to ask.

Date: _____
 DD MM YYYY

Personal information:

First name: _____ Last name: _____

Birth date: _____ Sex: M F
 DD MM YYYY

Address: _____ City, Province _____

Postal code: _____

Home phone: _____ Work phone: _____

Email: _____ Occupation: _____
(for appt. reminders & newsletters)

Emerg. contact: _____ Phone: _____

Reason for visit today _____

Is this injury the result of a workplace accident or injury? Y N

Is this injury the result of a motor vehicle accident that has occurred within the last 90 days? Y N

If yes, has AB-1 form been completed? Y N

Are you pregnant? If so, please indicate how many weeks and estimated due date. Y Gestation: _____ Due date: _____

How long have you had this condition? _____

Are you under the care of other health care practitioners? Y N

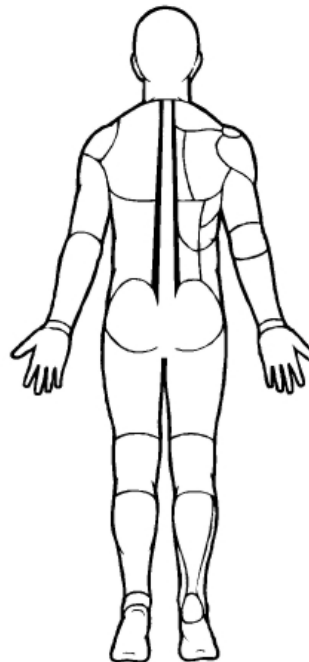
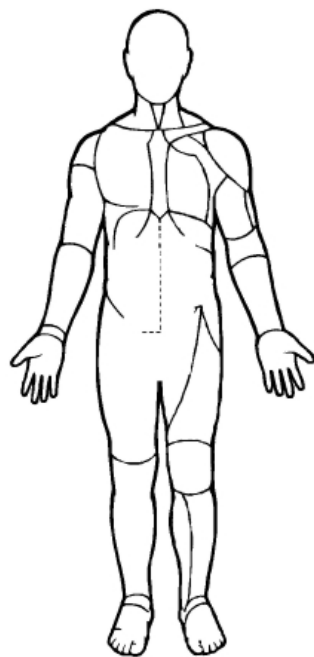
Other concurrent therapies: _____

Referred by/how you found out about us: _____

Pain measurement scale

In the past 4 weeks....

1.How much bodily pain have you had?	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
2.How much did pain interfere with your work (including both work outside home and housework)?	None <input type="checkbox"/>	A bit <input type="checkbox"/>	Moderately <input type="checkbox"/>	Extremely <input type="checkbox"/>
3.How much did pain interfere with your enjoyment of life?	Never <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>
4.How often did pain make simple tasks hard to complete?	Never <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>
5.How often were your leisure activities affected by your pain (including exercise and hobbies)?	Never <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>
6.How often did pain make you feel fed up and frustrated?	Never <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>



Please indicate areas of pain or discomfort on the diagrams above.

Medication

Please list any medication you are currently taking:

Family medical history

- | | | | | |
|------------------------------------|--|---|--|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |

Other: _____

Personal medical history

Check any of the following conditions you currently have.

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Major trauma
(car accident, fall, etc) List: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Surgery
List: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | _____ |

Cancellation policy: please note that we require 24 hours notice for appointment cancellations. There is a fee for missed or canceled appointments without sufficient notice.

Consent for treatment

I, _____ hereby request and CONSENT to treatment utilizing any combination of the following: acupuncture, herbal prescriptions, Chinese physical therapy (tui na), homeopathic medicine, physical therapy, exercise therapy, joint mobilizations, massage therapy, psychological counseling to be performed by Meridian Health Centre practitioners.

I understand with acupuncture treatment that there are some very slight risks to treatment, including but not limited to: bruising, minor bleeding, pain and discomfort. I understand that sterile, single use needles are used in all treatments.

I authorize sharing of relevant health information between Meridian Health practitioners for the purpose of treatment coordination.

I have had the opportunity to discuss with office/clinic personnel the nature and purpose of therapies mentioned above. I understand that results are not guaranteed.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above mentioned modalities of treatment. I intend this consent form to cover the entire course of treatment for any and all conditions treated at Meridian Health Centre.

PATIENT SIGNATURE (or guardian)

Signed this _____ day of _____ 20____

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