



Dr. Nicole Bend  
Healing Hands Health and Wellness  
148 Tuscany Drive NW, Calgary, AB T3L 2C3  
**Phone:** 403.465.4328 **Email:** [dr.nicolebend@gmail.com](mailto:dr.nicolebend@gmail.com) **Web:** [www.healinghandshealth.com](http://www.healinghandshealth.com)

### PATIENT INTAKE FORM

Date:					
Surname:		First Name:			
Date of Birth (M/D/Y):		Age:		Sex:	<input type="checkbox"/> F <input type="checkbox"/> M
Address:					
City:		Province:		Postal Code:	
Family Doctor:					
Business Employer:		Occupation:			

#### Contact Information

Home:		Business:	
Cell:		Email:	

#### How were you referred to us?

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#### Please provide the reason for your visit:

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?
How long has it been since your first noticed any symptoms?
Have you consulted a physician in regards to your condition?
What (if any) medical diagnoses have you received?
What (if any) treatments have/are you receiving?
Is there anything that makes it better?
Is there anything that makes it worse?



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### MEDICAL HISTORY

List any medications, herbs or nutritional supplements you are currently taking:

Name of Medication	Reason for usage?	Length of time taken?

**Personal Health History** (Please check any conditions or symptoms that apply to you):

<input type="checkbox"/> Accidents / significant trauma	<input type="checkbox"/> Addiction(s)	<input type="checkbox"/> Aids
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Arthritis-Rheumatoid/Osteo	<input type="checkbox"/> Asthma / Bronchitis / Pneumonia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Candida	<input type="checkbox"/> Colitis
<input type="checkbox"/> Cholesterol Issues	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Common Allergies	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Diabetes I or II
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Gastritis/Pancreatitis	<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High / Low Blood Pressure
<input type="checkbox"/> HIV+	<input type="checkbox"/> Hives	<input type="checkbox"/> Hypo / Hyperglycaemia
<input type="checkbox"/> IBS	<input type="checkbox"/> Infertility	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Impotence	<input type="checkbox"/> Kidney Issues	<input type="checkbox"/> Liver / Gall Bladder Disease
<input type="checkbox"/> Migraines	<input type="checkbox"/> Prostrate	<input type="checkbox"/> Seizures / Epilepsy
<input type="checkbox"/> Skin Disorders	<input type="checkbox"/> Stroke	<input type="checkbox"/> Surgeries
<input type="checkbox"/> TB	<input type="checkbox"/> Thyroid Imbalances	<input type="checkbox"/> Osteoporosis

#### Other Relevant Medical History


#### Lifestyle

Do you follow a regular exercise program? If so, please describe:		
Please describe your average daily diet:		
Food allergies / intolerance:		
Check any of the following habits that apply. How much and how often?		
Cigarettes <input type="checkbox"/>	Coffee, tea or cola <input type="checkbox"/>	Alcoholic beverages <input type="checkbox"/>



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### GENERAL TRADITIONAL CHINESE MEDICINE HEALTH HISTORY

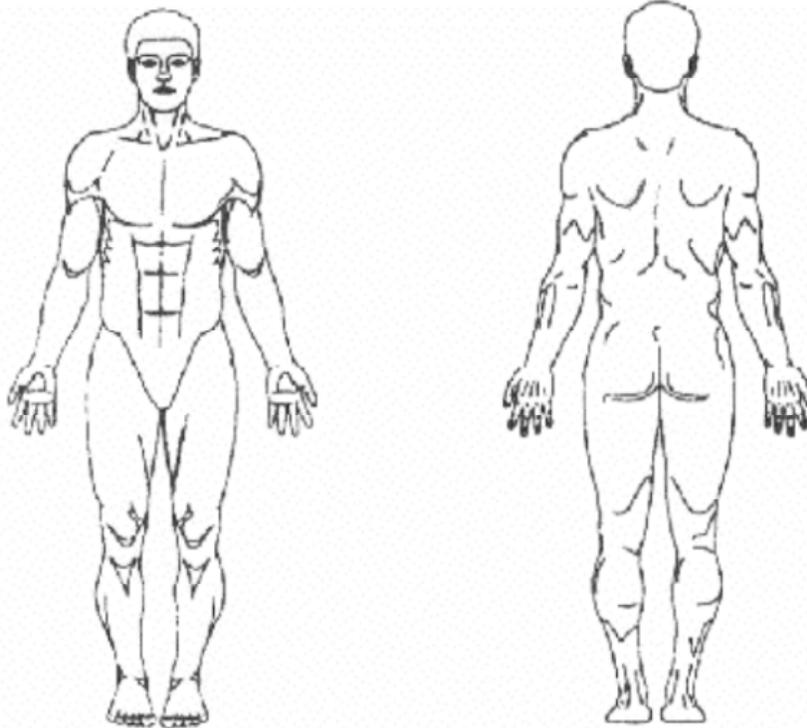
During the day do you feel: <input type="checkbox"/> chills <input type="checkbox"/> fever <input type="checkbox"/> both <input type="checkbox"/> perspiration when not active	Respiratory: <input type="checkbox"/> breathing difficulties <input type="checkbox"/> sinus problems <input type="checkbox"/> nose bleeds <input type="checkbox"/> cough <input type="checkbox"/> excessive phlegm
Do you prefer to drink: <input type="checkbox"/> warm / hot fluids <input type="checkbox"/> cold fluids  Are you frequently thirsty? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> sometimes  How much water do you drink in a day?	At night, I" <input type="checkbox"/> have difficulty falling asleep <input type="checkbox"/> have difficulty staying asleep If so, what times are you waking up? <input type="checkbox"/> have dreams that wake me up <input type="checkbox"/> wake up feeling hot / sweaty <input type="checkbox"/> feel anxious* <input type="checkbox"/> have heart palpitations* <i>*Please indicate if during the day also</i>
How is your appetite? <input type="checkbox"/> good <input type="checkbox"/> normal <input type="checkbox"/> poor <input type="checkbox"/> I experience "gnawing hunger"  After eating do you experience? <input type="checkbox"/> bloating <input type="checkbox"/> gas <input type="checkbox"/> acid regurgitation <input type="checkbox"/> fatigue / sleepiness <input type="checkbox"/> nausea / vomiting <input type="checkbox"/> cravings for sweet/salty	Hair, teeth, eyes: <input type="checkbox"/> have experienced hair, teeth loss <input type="checkbox"/> premature greying <input type="checkbox"/> clench or grind your teeth <input type="checkbox"/> eyes get dry, blurry, strained when tired <input type="checkbox"/> see 'floaters'
Energy levels: <input type="checkbox"/> frequently tired <input type="checkbox"/> have normal energy levels <input type="checkbox"/> better than normal	Skin: <input type="checkbox"/> rashes <input type="checkbox"/> eczema <input type="checkbox"/> hives/urticaria <input type="checkbox"/> pimples/acne <input type="checkbox"/> ulcerations
Urinary: <input type="checkbox"/> I wake during the night to urinate <input type="checkbox"/> I urinate first thing when I wake <input type="checkbox"/> unusual colour <input type="checkbox"/> unusual odour <input type="checkbox"/> mucus in your urine <input type="checkbox"/> burning sensation <input type="checkbox"/> have frequent urination <input type="checkbox"/> urgency to urinate <input type="checkbox"/> incontinence	Reproductive/gynaecological: Birth control: <input type="checkbox"/> yes <input type="checkbox"/> no   How long? Age of first menses?                      Age of menopause? Number of days in cycle? Regular cycles? <input type="checkbox"/> yes <input type="checkbox"/> no   Painful? <input type="checkbox"/> yes <input type="checkbox"/> no Flow of your bleeding? <input type="checkbox"/> light <input type="checkbox"/> normal <input type="checkbox"/> heavy What color is the blood? <input type="checkbox"/> light red <input type="checkbox"/> red <input type="checkbox"/> dark red <input type="checkbox"/> purple <input type="checkbox"/> brown <input type="checkbox"/> black Is there clotting? If yes, are they <input type="checkbox"/> big <input type="checkbox"/> small Do you bleed or spot between periods? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> vaginal discharge <input type="checkbox"/> PMS <input type="checkbox"/> Breast pain/lumps <input type="checkbox"/> endometriosis <input type="checkbox"/> cervical dysplasia <input type="checkbox"/> cysts/fibroids Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no No of pregnancies?                      No of miscarriages?
Bowel Movements: <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> mucus <input type="checkbox"/> runny <input type="checkbox"/> dry <input type="checkbox"/> rectal pain <input type="checkbox"/> frequency <input type="checkbox"/> urgency to go first thing in the am	Neuropsychological: <input type="checkbox"/> anxiety <input type="checkbox"/> panic attacks <input type="checkbox"/> fearfulness <input type="checkbox"/> poor memory <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> depression <input type="checkbox"/> irritability/anger <input type="checkbox"/> seizures <input type="checkbox"/> racing thoughts/worry <input type="checkbox"/> dizziness <input type="checkbox"/> loss of balance <input type="checkbox"/> have you ever been treated for emotional problems?



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<b>PAIN</b>			
Indicate type of pain:			
<input type="checkbox"/> sharp	<input type="checkbox"/> dull	<input type="checkbox"/> pulling	<input type="checkbox"/> hot
<input type="checkbox"/> moving	<input type="checkbox"/> achy	<input type="checkbox"/> throbbing	<input type="checkbox"/> cold
<input type="checkbox"/> weakness	<input type="checkbox"/> numbness	<input type="checkbox"/> tingling	<input type="checkbox"/> tension
What makes the pain / discomfort better or worse?			
application of cold:	<input type="checkbox"/> better	<input type="checkbox"/> worse	application of heat:
application of pressure:	<input type="checkbox"/> better	<input type="checkbox"/> worse	when resting:
when active:	<input type="checkbox"/> better	<input type="checkbox"/> worse	when tired:
when under stress:	<input type="checkbox"/> better	<input type="checkbox"/> worse	upon waking:
in the evening / night:	<input type="checkbox"/> better	<input type="checkbox"/> worse	<input type="checkbox"/> better
			<input type="checkbox"/> worse

Please circle location of pain/discomfort on chart below:



<i>Office use only</i>					
PULSE RIGHT		PULSE LEFT		TONGUE	
LU		HT			
SP		LV			
KI YANG		KI YIN			



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### CANCELLATION POLICY

We understand at Healing Hands Health and Wellness that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for schedules appointments to be cancelled at least 24 hours in advance.

We want to be available for your needs and the needs of our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours notice, you will be charged the FULL FEE.

MasterCard and Visa are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: \_\_\_\_\_ Printed Name:

Date:

*Signature of Parent or Guardian if the Patient is under 18 years of age:*

### INFORMED CONSENT

I understand that I should be evaluated by Dr. Nicole Bend, Registered Acupuncturist (the Acupuncturist) for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Acupuncturist is based on Traditional Chinese Medicine, and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking. I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I will inform the Acupuncturist if I have any condition and/or are taking any medication that interferes with blood clotting. I will notify the Acupuncturist if I have a pacemaker as electrical stimulation is contraindicated. I will notify my Acupuncturist should I become pregnant or if I am trying to become pregnant as certain acupuncture protocols are contraindicated (while other TCM treatments are favourable). I understand that the Acupuncturist may review my records but all information will be kept confidential and will not be released without my written consent. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am currently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am currently taking. I assume all risks and responsibilities for myself and release Dr. Nicole Bend and Healing Hands Health and Wellness clinic from any injury or liability that may occur during a treatment session.

Please sign and date below to indicate that you have read and understood this form.

Signature: \_\_\_\_\_ Printed Name:

Date:

*Signature of Parent or Guardian if the Patient is under 18 years of age:*