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 **Web**: www.healinghandshealth.com

PATIENT INTAKE FORM

Date:					
Surname:		First Name:			
Date of Birth (M/D/Y):		Age:		Sex:	❐ F ❐ M
Address:					
City:		Province:		Postal Code:	
Family Doctor:					
Business Employer:		Occupation:			

Contact Information

Home:		Business:	
Cell:		Email:	

How were you referred to us?

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):

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

Other Relevant Medical History

Lifestyle

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

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

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PAIN

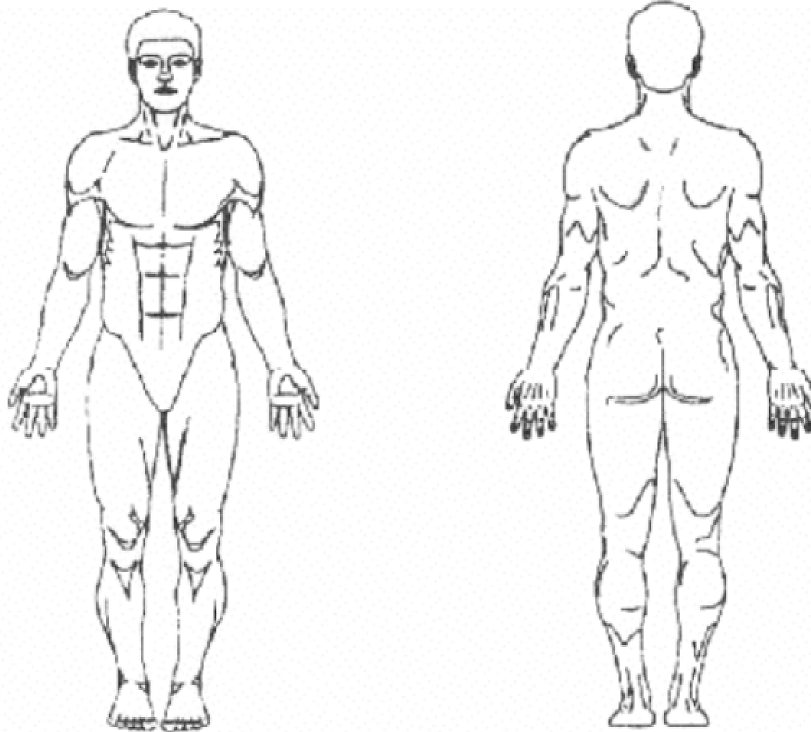
Indicate type of pain:

❒ sharp	❒ dull	❒ pulling	❒ hot	❒ cold
❒ moving	❒ achy	❒ throbbing	❒ pulsing	❒ tension
❒ weakness	❒ numbness	❒ tingling	❒ shooting	

What makes the pain / discomfort better or worse?

application of cold:	❒ better	❒ worse	application of heat:	❒ better	❒ worse
application of pressure:	❒ better	❒ worse	when resting:	❒ better	❒ worse
when active:	❒ better	❒ worse	when tired:	❒ better	❒ worse
when under stress:	❒ better	❒ worse	upon waking:	❒ better	❒ worse
in the evening / night:	❒ better	❒ worse			

Please circle location of pain/discomfort on chart below:



Office use only

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 and 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: