PLEASE FILL OUT AS ACCURATELY AS POSSIBLE

Patient Intake Form

PERSONAL INFORMATION

NAME → FIRST | INITIAL | LAST

ADDRESS

CITY | PROVINCE | POSTAL CODE | HOME PHONE

EMAIL ADDRESS | SEX | WORK PHONE

DATE OF BIRTH | CELL PHONE

HEALTHCARE INFORMATION

EMERGENCY CONTACT | EMERGENCY PHONE

REGULAR DOCTOR | DOCTOR'S PHONE

REFERRING DOCTOR | REFERRER'S PHONE

CARE CARD NUMBER | YES | NO — MSP ASSISSTANCE?

WCB | ICBC | DVA | DND | RCMP — IF MAKING A CLAIM, CHOOSE ONE

DATE OF INJURY

CURRENT OR PAST MEDICAL CONDITIONS

- ☐ STROKE
- ☐ CHRONIC PAIN
- ☐ HEART DISEASE
- ☐ HERNIA
- ☐ AIDS
- ☐ BLEEDING DISORDER
- ☐ ALCOHOLISM
- ☐ BRONCHITIS
- ☐ ALLERGIES
- ☐ BULIMIA
- ☐ HIGH BLOOD PRESSURE
- ☐ ARTHRITIS TYPE
- ☐ HIGH CHOLESTEROL
- ☐ CATARACTS
- ☐ DIABETES TYPE
- ☐ CHEMICAL DEPENDENCY
- ☐ ANEMIA
- ☐ CHICKEN POX
- ☐ CANCER TYPE
- ☐ ECZEMA
- ☐ ANOREXIA
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ EPILEPSY
- ☐ FATIGUE PROBLEM
- ☐ GALLBLADDER PROBLEM
- ☐ GERMAN MEASLES
- ☐ GLAUCOMA
- ☐ GOITER
- ☐ GOUT
- ☐ HEPATITIS
- ☐ HERPES
- ☐ INTESTINAL DISORDER
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUPUS
- ☐ MEASLES
- ☐ MENSTRUAL DISORDER
- ☐ MIGRAINES
- ☐ MISCARRIAGE
- ☐ MONONUCLEOSIS
- ☐ MULTIPLE SCLEROSIS
- ☐ MUMPS
- ☐ PACEMAKER
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTATE PROBLEM
- ☐ PSYCHIATRIC CARE
- ☐ RHEUMATIC FEVER
- ☐ STOMACH DISORDER
- ☐ THYROID DISORDER
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ URINARY TRACT INFECTION
- ☐ VAGINAL INFECTION
- ☐ VENEREAL DISEASE
- ☐ *OTHER*

What made you decide to visit our clinic today?

Do you have specific goals/expectations for your treatment?

List any and all prescription medications, herbs and supplements you are currently taking.

JANETTE CORMIER, RAc, RH | Port Alberni, BC | (250) 720-7240 | www.janettecormier.com

The information you provide on this form and during the treatment is confidential. Please answer the questions honestly, as it will help us to choose an appropriate treatment plan for you.

Symptoms

Please mark any symptoms you are currently experiencing with a *C*, mark all others you've experienced in the recent past with a *P*.

GENERAL
- ☐ FATIGUE
- ☐ INSOMNIA
- ☐ DISTURBED SLEEP
- ☐ FREQUENT DREAMS
- ☐ EXCESSIVE SLEEP
- ☐ DISLIKE COLD
- ☐ DISLIKE HEAT
- ☐ WEIGHT LOSS
- ☐ WEIGHT GAIN
- ☐ FEVER
- ☐ CHILLS
- ☐ NIGHT SWEATS
- ☐ UNUSUAL DAYTIME SWEATING
- ☐ USUALLY THIRSTY
- ☐ SELDOM THIRSTY
- ☐ EDEMA/SWELLING

SKIN
- ☐ RASHES
- ☐ HIVES
- ☐ DRY SKIN
- ☐ ACNE
- ☐ EASILY BRUISED
- ☐ CHANGES IN LUMPS/MOLES
- ☐ UNUSUAL BLEEDING
- ☐ OTHER

NERVOUS SYSTEM
- ☐ FAINTING
- ☐ PARALYSIS
- ☐ TREMORS
- ☐ POOR BALANCE
- ☐ SEIZURES

EYES & EARS
- ☐ FAILING VISION
- ☐ BLURRED VISION
- ☐ VISUAL SPOTS
- ☐ NIGHT BLINDNESS
- ☐ EYE PAIN/SWELLING
- ☐ RINGING IN EARS
- ☐ DECREASED HEARING
- ☐ EAR PAIN
- ☐ EAR DISCHARGE

HEART/LUNGS/CHEST
- ☐ PALPITATIONS
- ☐ CHEST PAIN
- ☐ TIGHTNESS
- ☐ RAPID HEART BEAT
- ☐ IRREGULAR HEART BEAT
- ☐ SWELLING OF THE ANKLES
- ☐ COUGH
- ☐ DRY COUGH
- ☐ COUGHING UP PHLEGM
- ☐ COUGHING UP BLOOD
- ☐ SHORTNESS OF BREATH
- ☐ ASTHMA/WHEEZING
- ☐ FREQUENT COLDS
- ☐ PAIN IN RIB CAGE

MUSCLES AND JOINTS
- ☐ PAIN, WEAKNESS OR NUMBNESS IN:
- ☐ NECK/SHOULDER/ARM/HAND
- ☐ HIPS/LEG/FEET
- ☐ SORE LOW BACK AND KNEES
- ☐ MUSCLE CRAMPS
- ☐ EYES AND EARS
- ☐ BODY PAIN
- ☐ HEAVY LIMBS
- ☐ SWOLLEN LIMBS
- ☐ HOT JOINTS

HEAD & NECK
- ☐ HEADACHES
- ☐ DIZZINESS
- ☐ JAW PAIN

MENTAL/EMOTIONAL
- ☐ DIFFICULTY CONCENTRATING
- ☐ POOR MEMORY
- ☐ WORRY
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ IRRITABILITY
- ☐ FRUSTRATION/ANGER
- ☐ FEARFULNESS
- ☐ STRESS

DIGESTIVE SYSTEM
- ☐ NAUSEA
- ☐ VOMITING FOOD
- ☐ VOMITING BLOOD
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ LOOSE STOOLS
- ☐ BLOODY/BLACK STOOL
- ☐ STOMACH PAIN
- ☐ ABDOMINAL PAIN
- ☐ POOR APPETITE
- ☐ EXCESSIVE HUNGER
- ☐ ABDOMINAL BLOATING/GAS
- ☐ BELCHING
- ☐ INDIGESTION
- ☐ ACID REFLUX
- ☐ HEMORRHOIDS

NOSE/THROAT/MOUTH
- ☐ NOSE BLEEDS
- ☐ NASAL DISCHARGE/INFECTION
- ☐ FREQUENT SNEEZING
- ☐ CHANGE IN SENSE OF SMELL
- ☐ SORE THROAT
- ☐ HOARSENESS
- ☐ DIFFICULTY IN SWALLOWING
- ☐ CHANGE IN SENSE OF TASTE
- ☐ TOOTH OR GUM PAIN
- ☐ BLEEDING GUMS
- ☐ MOUTH OR TONGUE ULCERS

URINARY/GENITAL
- ☐ PAINFUL URINATION
- ☐ DIFFICULT URINATION
- ☐ FREQUENT DAYTIME URINATION
- ☐ FREQUENT NIGHT URINATION
- ☐ INCONTINENCE
- ☐ CLOUDY URINE
- ☐ BLOODY URINE
- ☐ GENITAL PAIN OR ITCH
- ☐ GENITAL DISCHARGE OR LESIONS
- ☐ PAINFUL INTERCOURSE
- ☐ LOW SEXUAL DRIVE
- ☐ EXCESSIVE SEXUAL DRIVE

MALE
- ☐ IMPOTENCE
- ☐ WEAK URINARY STREAM
- ☐ PROSTATE HYPERTROPHY
- ☐ PREMATURE EJACULATION
- ☐ SEMINAL EMISSIONS

FEMALE
- ☐ IRREGULAR PERIODS PAINFUL PERIODS
- ☐ BLEEDING BETWEEN PERIODS
- ☐ PASSING CLOTS
- ☐ EARLY PERIODS SCANTY PERIODS
- ☐ NO PERIODS
- ☐ PMS
- ☐ MENOPAUSAL SYMPTOMS
- ☐ ABNORMAL PAP SMEAR
- ☐ BREAST LUMP
- ☐ BREAST PAIN OR DISCHARGE
- ☐ VAGINAL DISCHARGE

LEGAL INFORMATION: I understand that acupuncture and herbal medicine does not replace the need for conventional medical treatment. I understand that Janette Cormier cannot provide medical diagnosis, and that I must consult with a physician in order to obtain a diagnosis.

Acupuncture involves the insertion of thin, sterile needle into specific points on the body. Other therapies may also be used during an acupuncture treatment including moxa, cupping, gua sha, and acupressure. There are risks associated with acupuncture, moxa, cupping, gua sha, and acupressure, including but not limited to: discomfort, pain, bruising, burns, weakness, fainting, nausea, and sometimes aggravation of symptoms.

Herbal medicine involves the potential use of plant and fungi material through oral, topical, and suppository forms. There are potential risks associated with the use of herbal medicines, including but not limited to: allergic reactions, digestive upset, aggravation of symptoms, and toxicity due to contamination.

I am aware of the potential risks associated with acupuncture and herbal medicine and hereby release Janette Cormier of any and all liability which may occur with the above mentioned procedures, except failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation with these procedures at any time.

I, the undersigned, have read the legal information and verify that the medical information I have provided is true. I, knowing the potential risks, hereby consent to the use of acupuncture and herbal medicines and understand that I may withdraw this consent at any time.

☐ - **I CONSENT TO HAVE MSP PREMIUM ASSISTANCE BILLED FOR A PORTION OF MY TREATMENTS.**

SIGNATURE:	**PARENT/GUARDIAN:** (If under 18 years of age)
DATE:	**DATE:**