PERFORMANCE
INTEGRATED HEALTH
120 - 2630 Croydon Drive South Surrey BC V3Z 6T3
T 604 535 7705 E info@performancechiropractic.ca

Patient Information

Date

First name | Last name

Middle name(s) | I go by

Care Card/Services Card number (PHN)

Birthdate (yy/mm/dd) | Age | Please circle: Male Female Other

Home address

City | Postal code

Home telephone | Cellphone

Email (We will not share, rent or sell your email address.)

I would like to be reminded of my upcoming appointments by… ☐ Email ☐ Text ☐ Both Email and Text
I consent to Performance Integrated Health staff and practitioners corresponding with me via the email address I have provided. ☐ Yes ☐ No
If by Text, please provide the name of your cellphone carrier (eg. Telus)

I would like to receive Performance Integrated Health's free email newsletter featuring clinic news and health and wellness information. ☐ Yes ☐ No (You may unsubscribe at any time.)

Is this condition part of an **ICBC** or **WCB** Claim? ☐ Yes ☐ No **If yes, please ask for additional forms.**

Occupation | Business/employer

Do you have an extended health plan? ☐ Yes ☐ No

Name of current General Practitioner (MD)

Date of last visit to GP | Reason for last visit

Are you seeing a medical specialist? ☐ Yes ☐ No | Name of specialist

Reason for seeing specialist

Emergency contact | Telephone

How did you learn about Performance Integrated Health?
Online: ☐ Clinic website ☐ Facebook ☐ Google ☐ Instagram ☐ Twitter ☐ Yahoo ☐ Yellow Pages

Referred by (Give us a name – we would like to say thank you!)

☐ I live nearby Other:

Office use only MSP: ☐ Yes ☐ No W/C ☐ CE ☐ NL ☐ WE ☐

Confidential Health Information

Reason for Today's Visit:

Other complaints

Have you had previous care from a... ☐ Chiropractor ☐ Massage Therapist ☐ Naturopath
If yes, name of practitioner _____ Approximate date of last visit _____
Did you have spinal x-rays? ☐ Yes ☐ No If yes, when?

Medications Please list any medications or supplements you are taking and state reasons for taking them.

Medications (prescription, over-the-counter)

Supplements (multivitamins, gingko, etc)

Surgeries/Hospitalizations Please list any surgeries you have had and the date.

Stress Level Overall stress level: ☐ none ☐ low ☐ medium ☐ high
Main reasons for stress

Exercise How often do you exercise?

Type of exercise

Smoking Do you currently smoke? ☐ Yes ☐ No How much? ___ per day For how long? ___years

Goals What would you like to gain from today's visit?

Are you pregnant? (Pls circle) Yes No Maybe If yes, what is your due date? _____
Do you have children? (Pls circle) Yes No
How many children do you have?

_____

If yes, by...(Pls Circle) vaginal delivery caesarean delivery
If applicable, please list # of miscarriages
If applicable, please list # of abortions _____
Menstrual cycle (Check all that apply): _____

__regular __irregular __cramps __painful cycle __ blood clots __ heavy flow __ light flow

Do you experience any of the following before or during your menstrual period (Check all that apply):
__ Breast tenderness / swelling __ Constipation __ Depression __ Diarrhea __ Fatigue __Headaches
__ Hot Flashes __ Insomnia __ Irritability __ Migraines __ Nausea __ Pain with Intercourse __ Water Retention

Do you have a history of any of the following:
__ Amenorrhea __ Breast Implants __ Endometriosis __ Hysterectomy __ Infertility __ Ovarian Cyst
__ Polycystic Ovaries __ Pelvic inflammatory disease (PID) __ Sexually Transmitted Infections
__ Tubal ligation __ Uterine Fibroids

Have you experienced menopause? (Pls Circle) Y N

Date of your last annual Pap/Breast exam: _____

Date of your last Mammogram: _____

Allergies

Please list all allergies or hypersensitivities in the following categories.

Medications

Foods

Environmental/chemical

Medications

Please check if you take or use any of the following.

☐ Alcohol ☐ Antacids ☐ Anti-inflammatory ☐ Caffeine ☐ Cortisone ☐ Laxatives ☐ Marijuana
☐ Pain relievers ☐ Sleeping pills ☐ Tranquilizers
☐ Other drugs (please list)

Family History

Please check if you have a family history of any of the following. ☐ I don't know my family history ☐
Arthritis ☐ Asthma/allergies ☐ Cancer ☐ Depression ☐ Diabetes ☐ Drug/alcohol abuse ☐ Epilepsy ☐
High blood pressure ☐ High cholesterol ☐ Kidney disease ☐ Mental illness ☐ Stroke
☐ Other (please list)

Sleep

Time you retire _____ Time you wake up _____
Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No
Do you wake rested in the morning? ☐ Yes ☐ No

Diet

Do you follow any particular diet regimens or restrictions? ☐ Yes ☐ No
Describe a typical day's dietary intake below.

Breakfast

Lunch

Dinner

Snacks

Fluids

What are the two most important health goals for you?

1. **2.**

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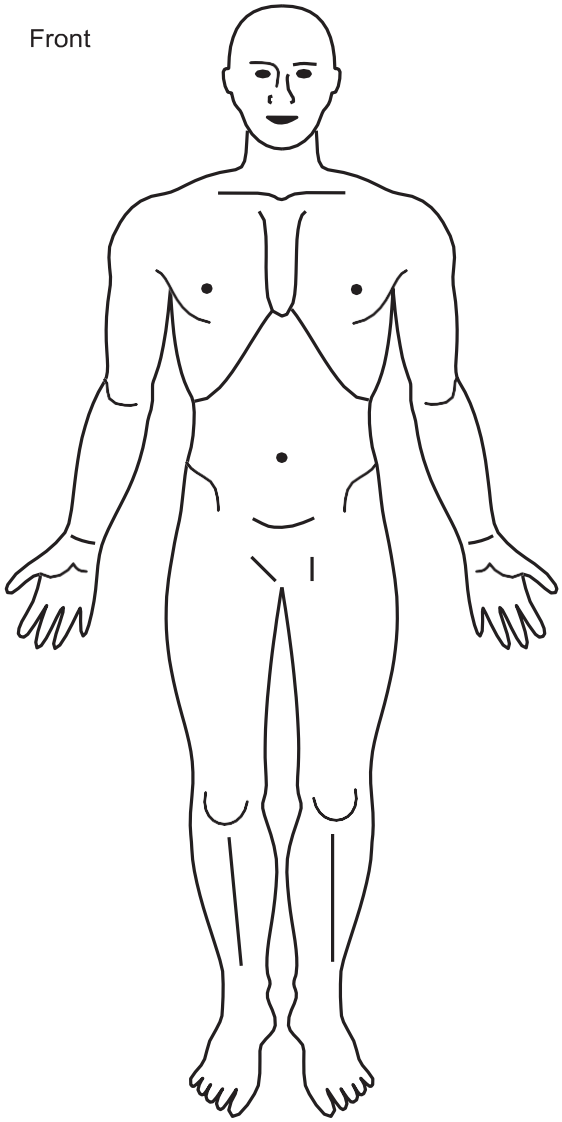
Area of Complaint and Pain Experienced

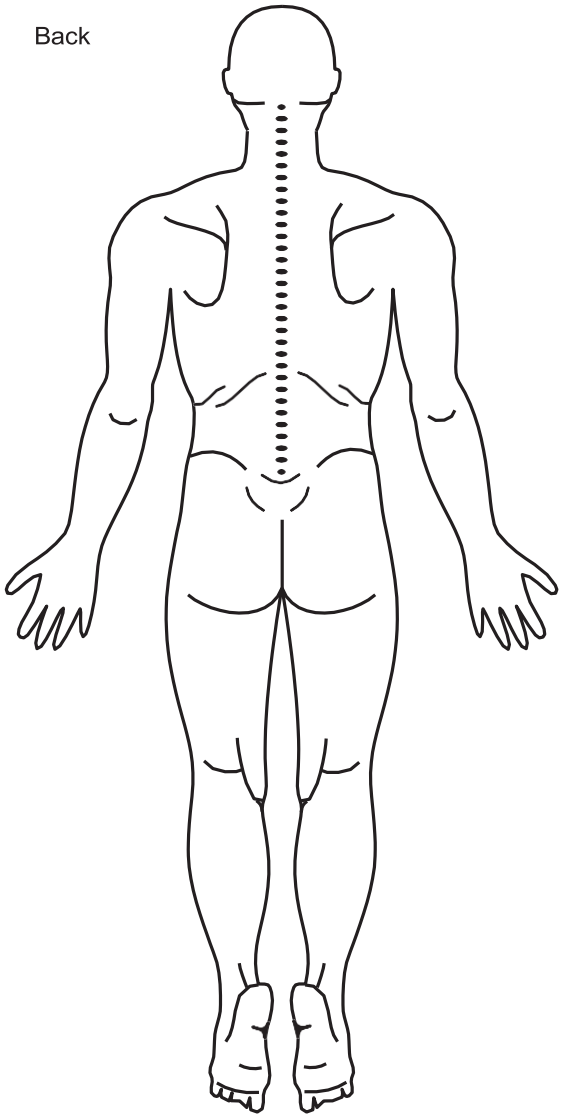
Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

X Burning O Dull/achy Δ Sharp □ Numbness/tingling

Front



Back



Acupuncture and Traditional Chinese Medicine
Declaration and Consent to Treatment

Please read the following carefully and enquire if you have any questions or concerns.

I understand that acupuncture treatments are a safe and natural form of healing and recognize the potential risks and benefits as stated below. Forms of treatment may include acupuncture, cupping, moxibustion, Gua sha (scraping), Tui na (Chiness massage), electrical stimulation, and dietary / lifestyle recommendations

Potential Benefits: Relief of presenting symptoms, improved health and wellbeing, reduced stress and a return to homeostasis of the body's internal physiology which may lead to prevention or elimination of the main complaint(s).

Potential Risks: Although uncommon, there is a potential for acupuncture treatments to cause minor bruising or bleeding, minor pain or soreness, nausea, weakness, fatigue, fainting or aggravation of existing symptoms for a short time. I understand certain, (but extremely rare) risks of acupuncture include infection, a stuck needle, and perforated viscera (pneumothorax). Moxibustion and cupping treatments carry the potential risks of temporary bruising or blistering.

I have reviewed and will notify my acupuncturist if any of the following conditions are present:

- Pregnancy
- Seizure Disorder
- Pacemaker
- Bleeding/Clotting disorders
- Local infections
- Joint replacement
- Diabetic

Cancellation Policy: I understand that scheduling an appointment involves the reservation of time at the clinic specifically for me, and I agree to give at least 24 hours of notice to cancel or reschedule an appointment. I will be charged 100% of cost for treatments missed without sufficient notice.

I have read and understood the above consent form. I am aware that if any of the conditions outlined change, it is my responsibility to notify my acupuncturist as soon as possible. I have had an opportunity to ask questions about its content, and by signing below, I agree to the above-mentioned acupuncture procedures. I understand that I can refuse treatment at any time.

Payment, changes to appointments and file sharing (require your initialing)

I accept full responsibility for any fees incurred during care and treatment, and am aware that I am responsible for payment at the time services are rendered. _____ (initials)

We require 24 hours of notice for any changes to, or cancellation of your appointment. All appointments missed, cancelled or rescheduled within 24 hours of the appointment will incur a penalty of 100% of visit cost. _____(initials)

I consent to my file being shared if I decide to see another practitioner at Performance. _____ (initials)

I confirm that I have read, or have had read to me, the above information and have had the opportunity to ask questions about its content. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I have been informed that I have the right to refuse any form of treatment.

I confirm that I am not an agent of any private, local, provincial, or federal agency to gather information without stating so. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

By signing below I give my informed consent to proceed with acupuncture and traditional Chinese medicine treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dated this day of ,20

Patient or Legal Guardian's Signature

Witness of Signature

Name
(please print)