

Quanfu Zhou Chinese Medicine & Acupuncture Clinic

212 Bathurst street Toronto, Ontario M5T 2R9

Tel: (416) 603-0236 Fax: (416) 572-2788

PATIENT INTAKE FORM

CONFIDENTIAL HEALTH HISTORY

First Name: _____ Last Name: _____ Gender: M () F ()

Date of Birth: (D) _____ (M) _____ (Y) _____ Occupation: _____

Address: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

Emergency Contact : Name: _____ Phone: _____ Relationship: _____

How did you get to know us? _____

Have you ever receive (if yes, please check): () Acupuncture () Herbal Treatment

Please describe your main concern(s). How long have you been affected?

Do you have or have you ever had the following? If yes, please Check:

Heart & Vascular System:

() Palpitation () High Blood Pressure () Low Blood Pressure () Heart Attack () Stroke
() Varicose veins () Poor Circulation

Respiratory System:

() Cough () Shortness of breath () Allergies () Asthma () Sinusitis
() Frequent Cold/Flu

Digestive System:

() Nausea () Vomiting () Acid Reflux () Stomach-ache () Abdomen Pain
() Diarrhea () Constipation () Gallstones () Hepatitis

Urinary System:

() Frequent urination () Painful urination () Kidney stones () Nephritis

Reproductive System:

() Painful menstruation () Irregular menstruation () Uterine Fibroids () Varian Cysts () Menopause disorder
() Infertility () Impotence () Prostatitis

Nervous System:

() Sleep Disorders () Parkinson's disease () Seizures () Alzheimer's disease

Skin Problems:

() Acne () Eczema () Dermatitis () Psoriasis () Rash
() Fungal () Infections () ()

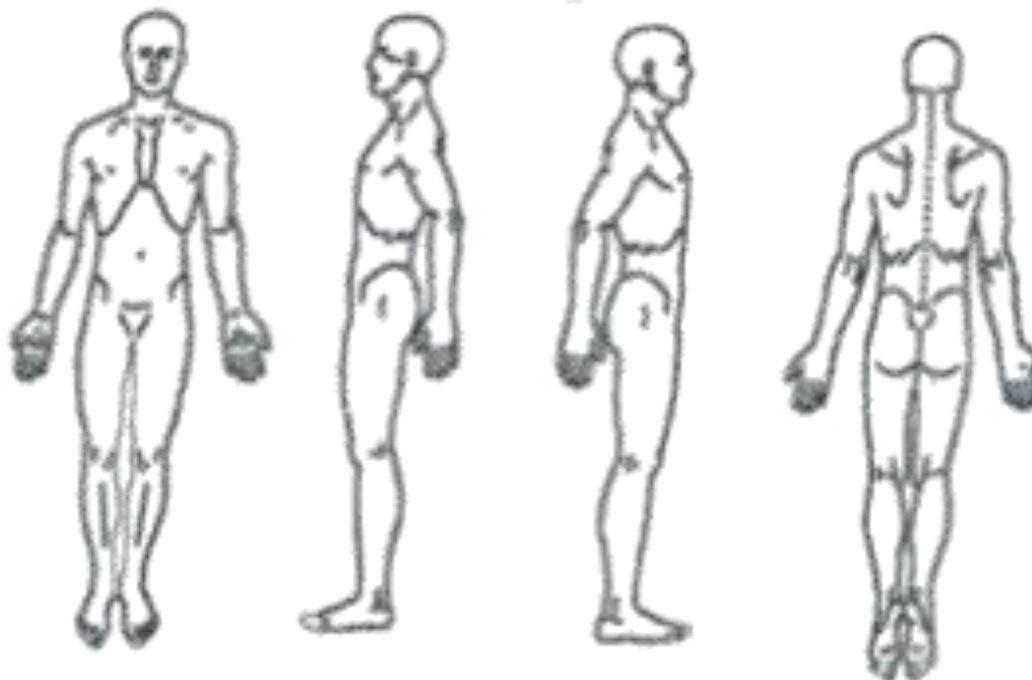
Others:

() Headache () Dizziness () Fatigue () Weight gain () Weight Loss
() Swelling () Flushes () Diabetes () Arthritis () Osteoporosis
() Fibromyalgia () Tumor () Cancer () ()

Emotions:

() Stress () Anxiety () Depression () Grief () Anger

Please Shade all areas of pain and/or discomfort



Do you have a pacemaker or any other electrical implants?

Yes No

Do you have a bleeding disorder?

Yes No

Are you Pregnant?

Yes No

If you are undergoing medical treatment, please list all current medications:

Treatment Options:

Your treatment may include Acupuncture(use only single-use, sterile, disposable needles),Chinese Herbs, Moxibustion, Cupping, Electro-Acupuncture, Acupressure, Dermal Friction (Guasha), Infra-red (Heat Lamps), Therapeutic Exercises and Nutritional Counselling

I come to this clinic for consultation and advice and accept the proposed treatment(s). I understand that I am free to withdraw my consent and I may stop treatment at any time.

Signature:

Print name:

Date:
