PARK INTEGRATIVE HEALTH

MASSAGE/ACUPUNCTURE INTAKE FORM

PERSONAL INFORMATION

Name: (First) _____ (Last):_____

Preferred Name: _____

Date of Birth (DOB) (YYYY/MM/DD):_____

Preferred Pronoun (Optional): _____

Occupation:_____

Address: _____

City: _____

Province: _____ Postal Code:_____

Primary Phone Number: _____

Alternate Phone Number:_____

Email: _____

Emergency Contact (Name):_____

Emergency Contact Number: _____

If the patient / client is a minor, please identify:

Name of Parent / Guardian:_____

Relationship to minor: _____

How did you hear about Park Integrative Health?

☐	Family or friend
☐	Print ad (e.g. newspaper, The Bugle)
☐	Social media (e.g. Facebook, Instagram, etc.)
☐	Mix 107.9 Radio Ad

Reasons for Visit (Rank by priority):

Priority	Complaint (e.g. headache)	Onset (e.g. May 2014)	Frequency (e.g. 4x/week)	Severity (mild, moderate or severe)
1				
2				
3				
4				

Please describe your past medical history:

Condition / Diagnosis (e.g. Acid Reflux)	Onset (e.g. May 2014)	Medical Procedures (e.g. May 2016)	Severity (mild, moderate or severe)

Please describe your surgeries or procedures:

Surgery / Procedure (e.g. Appendectomy)	When (e.g. June 2016)	Where (e.g. Grey Nuns)

Please describe any injuries you have sustained:

Injury (e.g. Fractured ribs)	Mode of Injury (e.g. Car accident)	When (e.g. June 2016)

Lifestyle Habits (Check all that apply):

☐	Tobacco	☐	Cigars
☐	Chewing Tobacco	☐	Alcohol
☐	Drugs		

Please check boxes relevant to your cardiovascular condition:

☐	Pacemaker	☐	Atherosclerosis
☐	Low blood pressure	☐	High blood pressure
☐	Fainting	☐	Chest pain
☐	Fast heart beat	☐	Slow heart beat
☐	Palpitations	☐	Stroke
☐	Heart attack	☐	Heart disease

Please check boxes relevant to your gastrointestinal condition:

☐	Nausea	☐	Vomiting
☐	Acid Reflux / Regurgitation	☐	Gas
☐	Hiccup	☐	Bloating after meals
☐	Bad breath	☐	Gurgling sounds
☐	Diarrhea	☐	Constipation
☐	Laxative use	☐	Black stools
☐	Blood in stool	☐	Mucous in stool
☐	Intestinal cramping	☐	Loose stool
☐	Undigested food in stool	☐	IBS
☐	Stomach cramps	☐	Itchy anus
☐	Burning anus	☐	Rectal pain
☐	Ulcerative colitis	☐	Hemorrhoids
☐	Gastritis	☐	Enteritis
☐	Hard stool	☐	Ulcers
☐	Colitis / Crohn's	☐	Appendicitis

Please check boxes pertaining to your sleep patterns:

☐	Insomnia	☐	Troubles falling asleep
☐	Troubles staying asleep	☐	Dream disturbed sleep
☐	Wake up tired	☐	Waking up in night

Please check boxes pertaining to respiratory conditions:

☐	Shortness of breath	☐	Tightness in chest
☐	Chest oppression	☐	Chronic cough
☐	Difficulty breathing lying down	☐	Asthma / wheezing
☐	Dry cough	☐	Productive cough
☐	A lot of sputum	☐	Little sputum
☐	Clear sputum	☐	Sticky sputum
☐	Blood in sputum	☐	Pleurisy
☐	Pneumonia	☐	Bronchitis
☐	Whooping cough	☐	Emphysema
☐	Tuberculosis	☐	Other:

Please check boxes pertaining to head, eyes, ears, nose and throat:

☐	Glasses	☐	Eye strain
☐	Red eyes	☐	Itchy eyes
☐	Spots in eyes	☐	Floaters
☐	Poor vision	☐	Blurred vision
☐	Night blindness	☐	Glaucoma
☐	Cataracts	☐	Grinding teeth
☐	TMJ / TMD	☐	Gum disease
☐	Sore gums	☐	Bleeding gums
☐	Sores on lips	☐	Sores on tongue
☐	Dry mouth	☐	Excessive saliva
☐	Sinus problems	☐	Clear throat often
☐	Recurrent sore throat	☐	Swollen glands

☐	Lumps in throat	☐	Enlarged thyroid
☐	Nose bleeds	☐	Ringing in ears
☐	Poor hearing	☐	Ear aches
☐	Headache	☐	Migraines

Please check boxes that apply to your Genito-urinary conditions:

☐	Painful urination	☐	Frequent urination
☐	Copious urination (a lot)	☐	Cloudy urination
☐	Scanty urination	☐	Urination at night
☐	Dark yellow urine	☐	Light yellow urine
☐	Clear urine	☐	Burning urination
☐	Retention of urine	☐	Frequent bladder infections
☐	Frequent kidney infections	☐	Urinary incontinence

Please check boxes pertaining to your skin and hair conditions:

☐	Rashes	☐	Hives
☐	Ulcerations	☐	Dry skin
☐	Eczema	☐	Psoriasis
☐	Shingles	☐	Oily skin
☐	Dandruff	☐	Acne
☐	Itchy skin	☐	Fungal infections
☐	Premature grey hair	☐	Alopecia (hair loss)

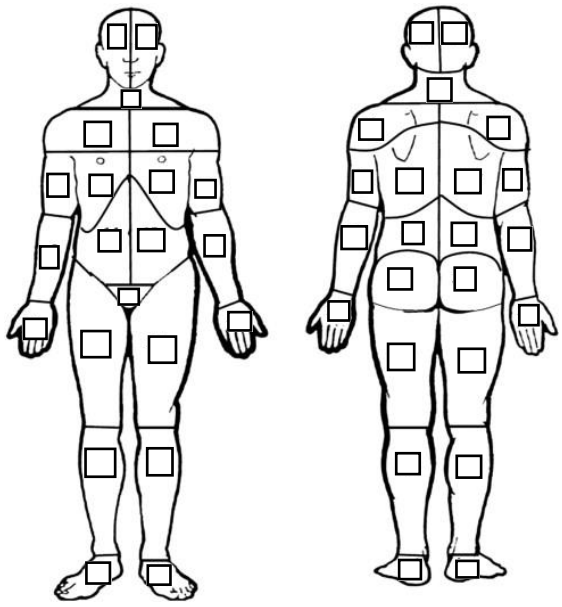
Please check boxes that apply to your neuropsychological conditions:

☐	Seizures	☐	Numbness
☐	Tingling	☐	Tics
☐	ADHD	☐	Parkinson's
☐	Trigeminal Neuralgia	☐	Bell's Palsy
☐	Fainting	☐	Epilepsy
☐	Alzheimer's	☐	Autism

Please check boxes that apply to your mental health conditions:

☐	Depression	☐	Generalized Anxiety Disorder (GAD)
☐	Personality Disorders (MPD, DID, ODD)	☐	Post-Traumatic Stress Disorder (PTSD)
☐	Bipolar Disorder	☐	Substance abuse and addictions
☐	Obsessive Compulsive Disorder	☐	Psychotic Disorder
☐	ADHD / ADD	☐	Panic Disorders
☐	Chronic Pain Disorder	☐	Somatization Disorder
☐	Other:		

Use the diagram below to indicate area(s) of pain, discomfort or tenderness



CANCELLATION POLICY

Park Integrative Health requests that changes to your appointment(s) are communicated via phone 24 hours prior to your scheduled appointment time.

A cancellation within 24 hours may result in a treatment charge of 50% to 100% of the original booking cost.

Printed Name:_____

Signature: _____ Date: _____

CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFIYNG HEALTH INFORMATION

[AUTHORIZED BY HIA s34]

(ADAPTED FROM HEALTH INFORMATION ACT: GUIDELINES AND PRACTICE)

Park Integrative Health is committed to collecting, using, and disclosing your personal information safely and responsibly.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high-quality care
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To establish and maintain communication with you
- To communicate with other treating health-care providers, including specialists, family practitioners, referring physicians, allied health providers of Park Integrative Health and any other provider involved in the care of a patient
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to Alberta Health Services (AHS), and other medical professionals, as required.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. Your information may be accessed by regulatory authorities under the terms of the Health Information Act (HIA).

I acknowledge that I have been made aware of why I have been asked to consent to the disclosure of the above information and am aware of the risks and benefits associated with consenting, or refusing to consent, to the disclosure of my individually identifying health information. I understand that I may revoke my consent at any time, by providing a signed, written statement to that effect.

Printed Name: _____

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby request and consent to treatment to be performed by practitioners of Park Integrative Health utilizing any combination of the following: massage, acupuncture, Chinese massage therapy (tui na), cupping, Gua Sha, selectronic moxibustion, Low Level Laser Therapy, sound therapy or energy healing.

I understand with acupuncture treatment that are slight risks to treatment, including but not limited to: bruising, minor bleeding, pain and discomfort. I understand that sterile, single use needles are used in all treatments.

I understand with massage therapy there are slight risks to treatment, including but not limited to: local soreness, bruising, dehydration, dizziness, increase/decrease in blood pressure.

Printed Name: _____

Signature: _____ Date: _____