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 | ☐ Male ☐ Female

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 ☐

Health and Wellness Survey

Reason for today's visit

How, when and where did this condition begin?

What makes it better?

What makes it worse?

What types of treatment have you tried, if any?

Have you received acupuncture before? ☐ Yes ☐ No If Yes, when?

Please list any other health problems you would like to address in order of importance

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (please circle) %: 10 20 30 40 50 60 70 80 90 100

Medical History

Please list surgeries, major illnesses, hospitalizations, accidents (include dates)

Do you have any environmental or food allergies? ☐ Yes ☐ No
If Yes, please list

Do you have any drug allergies? ☐ Yes ☐ No
If Yes, please list

Please list current medications, supplements and vitamins you are taking (and what they are for)

Immediate family medical history (mother, father, siblings)

Do you currently have or have you ever had any of the following? (please circle **P** for Past, **C** for Current)

P	C	AIDS	P	C	Epilepsy	P	C	Multiple sclerosis
P	C	Alcoholism	P	C	Fibromyalgia	P	C	Osteoporosis
P	C	Allergies	P	C	Gall Stones	P	C	Pacemaker
P	C	Anemia	P	C	Hayfever	P	C	Respiratory disease
P	C	Arthritis	P	C	Heart problem	P	C	Skin condition
P	C	Asthma	P	C	Hepatitis	P	C	Spinal injury
P	C	Bleeding disorder	P	C	High blood pressure	P	C	Stroke
P	C	Cancer	P	C	HIV	P	C	Sudden weight loss/gain
P	C	Chronic fatigue	P	C	Kidney disease	P	C	Thyroid problem
P	C	Deep vein thrombosis	P	C	Kidney stones	P	C	Tuberculosis
P	C	Diabetes	P	C	Liver disease	P	C	Ulcers
P	C	Digestive disorders	P	C	Low blood pressure	P	C	Varicose veins
P	C	Drug problem	P	C	Malaria			
P	C	Emotional disorder	P	C	Mental illness			

Diet and lifestyle

How do you feel about your diet?

Do you crave any particular foods?

Do you follow a special diet?

Please indicate your use and amount of the following

Water ______________________ Tea ______________________

Coffee ______________________ Soda pop ______________________

Alcohol ______________________ Cigarettes/Tobacco ______________________

Sleep aids ______________________ Laxatives ______________________

Cannabis ______________________ Recreational drugs ______________________

Do you exercise? ☐ Yes ☐ No If Yes, how often? ______________________

Type of exercise

Do you enjoy work? ☐ Yes ☐ No Hours per week working

Hobbies

Energy level (please circle) LOW - 1 2 3 4 5 6 7 8 9 10 - HIGH

Stress level (please circle) LOW - 1 2 3 4 5 6 7 8 9 10 - HIGH

Cause of stress?

Describe your emotions right now ☐ Content ☐ Stressed ☐ Worried ☐ Sad ☐ Depressed ☐ Angry

☐ Other (please describe)

Pain

☐ Headache/Migraine ☐ Chest ☐ Upper abdominal ☐ Lower abdominal ☐ Lumbago ☐ General body ache

Description of pain ☐ Acute ☐ Chronic ☐ Persistent ☐ Lingering

The pain is relieved by
☐ Heat ☐ Cold ☐ Pressure ☐ Massage

The pain is aggravated by
☐ Heat ☐ Cold ☐ Pressure ☐ Massage

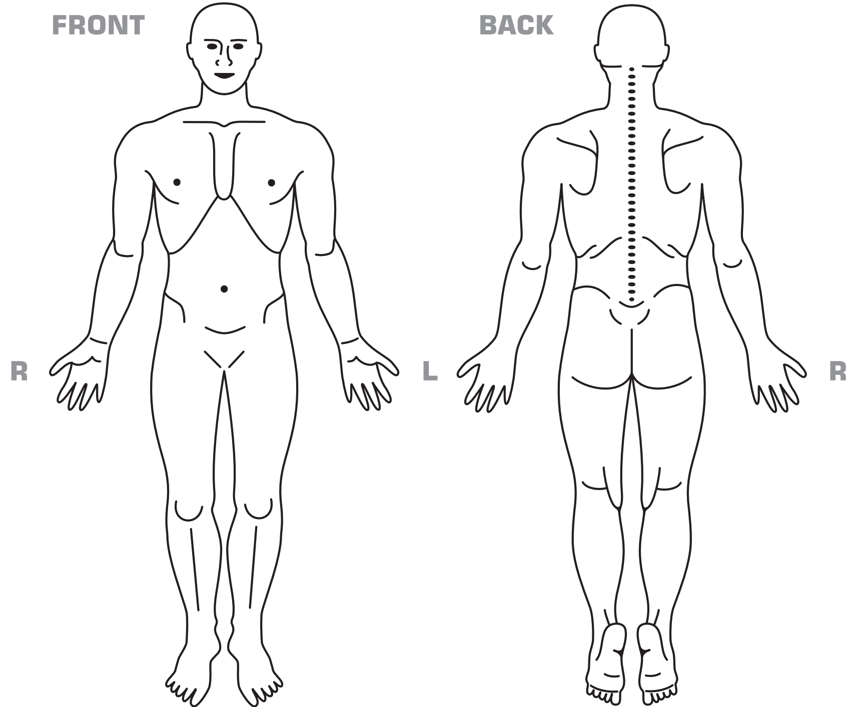
Using the following symbols, please indicate directly on the body diagrams at right the area of your complaint and the type of pain experienced.

X Sharp stabbing

△ Pins & needles

○ Numbness

☐ Dull



Sleep

Hours per night _______ Are you rested in the AM? ☐ Yes ☐ No Waking at what time? ______________

Do you have trouble falling asleep? ☐ Yes ☐ No Do you have trouble staying asleep? ☐ Yes ☐ No

Do you get up to urinate more than once? ☐ Yes ☐ No

Urination

Frequency ____ Volume ____

☐ Burning ☐ Urgent ☐ Scanty ☐ Difficult ☐ Profuse ☐ Dribbling ☐ More than 1x a night

☐ Deep yellow ☐ Hematuria ☐ Clear

Bowel movements

Frequency __________________ ☐ Well-formed ☐ Hard ☐ Loose

☐ Constipation ☐ Diarrhea ☐ Undigested food ☐ Blood ☐ Mucous

Sweating

☐ Normal ☐ Spontaneous ☐ Night sweating ☐ Profuse cold ☐ Never sweat

Odour? Location? Discoloration?

Are you thirsty? ☐ Yes ☐ No If Yes, do you prefer warm or cold drinks? ☐ Warm ☐ Cold ☐ Either

Do you feel generally hot or cold? ☐ No ☐ Hot ☐ Cold

Symptom Survey

For each symptom that you CURRENTLY have, rate its severity from 1-5 (5 being worst). Leave blank if not applicable.

Gan

___ Irritability/frustration/impatience

___ Depression

___ Stress

___ Emotional eating

___ Unfulfilled desires

___ Visual problems/floaters

___ Blurred vision/poor night vision

___ Red/dry/itchy eyes

___ Headaches/migraines

___ Dizziness

___ Feeling of lump in throat

___ Muscle twitching/spasm

___ Neck/shoulder tension

___ Brittle nails

___ Sighing

___ Sensation or pain under ribcage

___ PMS

___ Genital itching/pain/rashes

Xin

___ Palpitations

___ Chest pain/tightness

___ Insomnia/sleep problems

___ Restless/easily agitated

___ Vivid dreams

___ Lack of joy in life

___ Forgetful

___ Aversion to heat

___ Bitter taste in mouth

___ Tongue/mouth ulcers/cankers

Shen

___ Frequent urination

___ Bladder infection

___ Lack of bladder control

___ Wake to urinate

___ Feel cold easily

___ Cold hands/feet

___ Night sweats/hot flushing

___ Low sex drive

___ High sex drive

___ Loss of head hair

___ Hearing problems

___ Crave salty food

___ Fear

___ Poor long-term memory

___ Ankle swelling

___ Tinnitus

Fei

___ Dry cough

___ Cough with phlegm

___ Nasal discharge/drip

___ Sinus infection/congestion

___ Itchy/painful throat

___ Dry mouth/throat/nose

___ Skin rashes/hives

___ Snoring

___ Grief/sadness

___ Shortness of breath

___ Allergies/asthma

___ Weak immune system

___ Alternate fever/chills

Pi

___ Heaviness in the head/body

___ Fatigue/after eating

___ Difficult getting up in morning

___ Water retention

___ Muscular tired/weak

___ Bruise easily

___ Unusual bleeding (stool, nose, etc)

___ Bad breath

___ Poor appetite

___ Increased appetite

___ Crave sweets

___ Poor digestion

___ Nausea/vomiting

___ Bloating/gas

___ Hemorrhoids

___ Constipation

___ Loose stool

___ Alternate constipation/loose

___ Abdominal pain

___ Intestinal pain/cramping

___ Heartburn

___ Pensive/over-thinking

___ Overweight

___ Foggy mind

___ Yeast infection

___ Aversion to cold

___ Cold nose

___ Increased thirst

___ Prefer warm/cold drinks

___ Sweat easily

Sexual and Reproductive Health

For Women

Are you pregnant? ☐ Yes ☐ No Due date? Are you lactating? ☐ Yes ☐ No

No. of pregnancies No. of live births No. of miscarriages No. of abortions

Method of contraception ☐ None ☐ Birth Control Pill ☐ Copper IUD ☐ Hormonal IUD ☐ Condoms
☐ Other (please describe)

Have you experienced menopause? ☐ Yes ☐ No If Yes, when?

If you are experiencing menopausal symptoms, please describe

Vaginal Discharge? ☐ Yes ☐ No If Yes, indicate smell and colour

Is your period regular? ☐ Yes ☐ No When was the first day of your last period? ___________________________
How old were you when you had your first period?

No. of days from the start of one period to the start of the next ________ Average number of days of flow: ______
Flow is ☐ Light ☐ Normal ☐ Heavy
Color is ☐ Pale ☐ Normal ☐ Dark ☐ Bright red ☐ Brown ☐ Purple
Blood clots? ☐ Yes ☐ No Do you get pain or cramps? ☐ Yes ☐ No Severe? ☐ Yes ☐ No
Nature of pain ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Burning ☐ Aching

Do you experience any of the following before or during your menstrual period?
☐ Breast tenderness/swelling ☐ Constipation ☐ Depression ☐ Diarrhea ☐ Difficulty with orgasm
☐ Fatigue ☐ Headaches ☐ Hot flashes ☐ Insomnia ☐ Irritability ☐ Migraines ☐ Nausea
☐ Pain with intercourse ☐ PMS ☐ 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

When did you have your last Pap/Breast exam?

When did you have your last Mammogram?

Any history of abnormal tests? ☐ Yes ☐ No Other

For Men

Date of last prostate check up ________________________________
Results:

Please tick all of the following that apply to you
☐ Groin pain ☐ Testicular pain ☐ Erectile dysfunction ☐ Impotence ☐ Premature ejaculation
☐ Nocturnal emissions ☐ Painful urination ☐ Difficult urination ☐ Dribbling urination ☐ Incontinence
☐ Decreased libido ☐ Increased libido ☐ Difficulty with orgasm ☐ Sexually transmitted infections
☐ Vasectomy ☐ Other (please describe)

Acupuncture and Traditional Chinese Medicine Declaration and Consent to Treatment

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

Acupuncture, cupping, and other treatments provided by this clinic have been proven to be highly effective and very safe. However, we are required to inform patients that there may be some risks involved and that practitioners cannot anticipate all possible complications. The following are some of the side effects that can occur with acupuncture and associated treatments:

- *Residual needle sensation.* Sometimes there is a residual sensation at the point of insertion that may last for a period of time following treatment. Please inform your practitioner if this occurs and does not dissipate in 1-2 days.
- *Drowsiness or dizziness*. Please ensure that you eat and drink prior to treatment as these effects may be more common if you are hungry or dehydrated. If you feel drowsy or dizzy, you are strongly advised not to drive following treatment.
- *Fainting*. This is rare but can occur, particularly with new patients. Please ensure that you eat and drink prior to treatment as these effects may be more common if you are hungry or dehydrated. Please inform your practitioner if you are nervous of needles or have a history of fainting for any reason.
- *Minor bleeding or bruising*. This can occur as a result of acupuncture treatment.
- *Bruising resembling a "hickey"*. This is a common side effect of cupping. The marks are generally painless but can be accompanied by temporary tenderness.
- *Irritation of the skin*. This is generally due to allergies if a topical lotion or oil is used. You should inform us if you have any allergies.
- *Temporary aggravation of symptoms*. In a small percentage of patients, symptoms can become worse before improving. This is generally a sign that healing has begun. If the worsening of symptoms is severe or lasts more than two days, we urge you to contact us.

The following rare but serious acupuncture complications have been reported in literature. Precautions are always observed to avoid such complications.

- *Joint infection*. This can occur if bacteria on the skin are introduced to a joint by the needle. Some acupuncture joints go into the joint and can therefore introduce infection. This is very rare and has never been experienced by our practitioners.
- *Nerve damage*. Some acupuncture points are over nerves, and there is therefore the possibility of nerve damage. This is very rare and has never been experienced by our practitioners.
- *Pneumothorax (collapsed lung)*. If the needle is inserted too deeply between the ribs or above the lungs, it may pierce a lung and cause a pneumothorax. This is very rare and has never been experienced by our practitioners.
- *Needle breakage*. If a needle were to break during insertion, it may require surgical removal. Again, this is very rare and has never been experienced by our practitioners.

The use of sterilized, disposable needles at this clinic eliminates the risk of hepatitis B, hepatitis C and AIDS/HIV transmission. Our needles are used once and are then safely disposed of.

The herbal treatments used in Traditional Chinese Medicine (which can be from plant, animal, or mineral source) are considered safe when used in the manner recommended by a qualified practitioner. Your practitioner may use Chinese herbal formulas in the form of teas, powders, tablets, or topical applications. Some of the herbs may be inappropriate during pregnancy, with certain medical conditions or while taking other medications. It is important to inform your practitioner of all these situations and conditions.

Please note that our practitioners refuse to use herbal products made from endangered or protected species in this clinic.

Please initial to indicate you have read and understood this page _________ (initials)

continued on next page

Acupuncture and Traditional Chinese Medicine Declaration and Consent to Treatment (cont'd)

Possible side effects to herbal therapy include such things as allergic reactions, gastrointestinal upset or skin rashes. In the case of an adverse reaction to herbal therapy, it is important that you cease use immediately and inform your practitioner.

It is important that you inform us if any of the following apply to you:

- If you are pregnant;
- If you have a pacemaker or other electrical implant;
- If you have a bleeding disorder;
- If you are taking anti-coagulents (blood thinners) or any other medication;
- If you have any allergies;
- If you have ever felt faint or had any unusual or negative sensation from acupuncture or medical treatments;
- If you are at higher risk of infection.

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 50% 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.

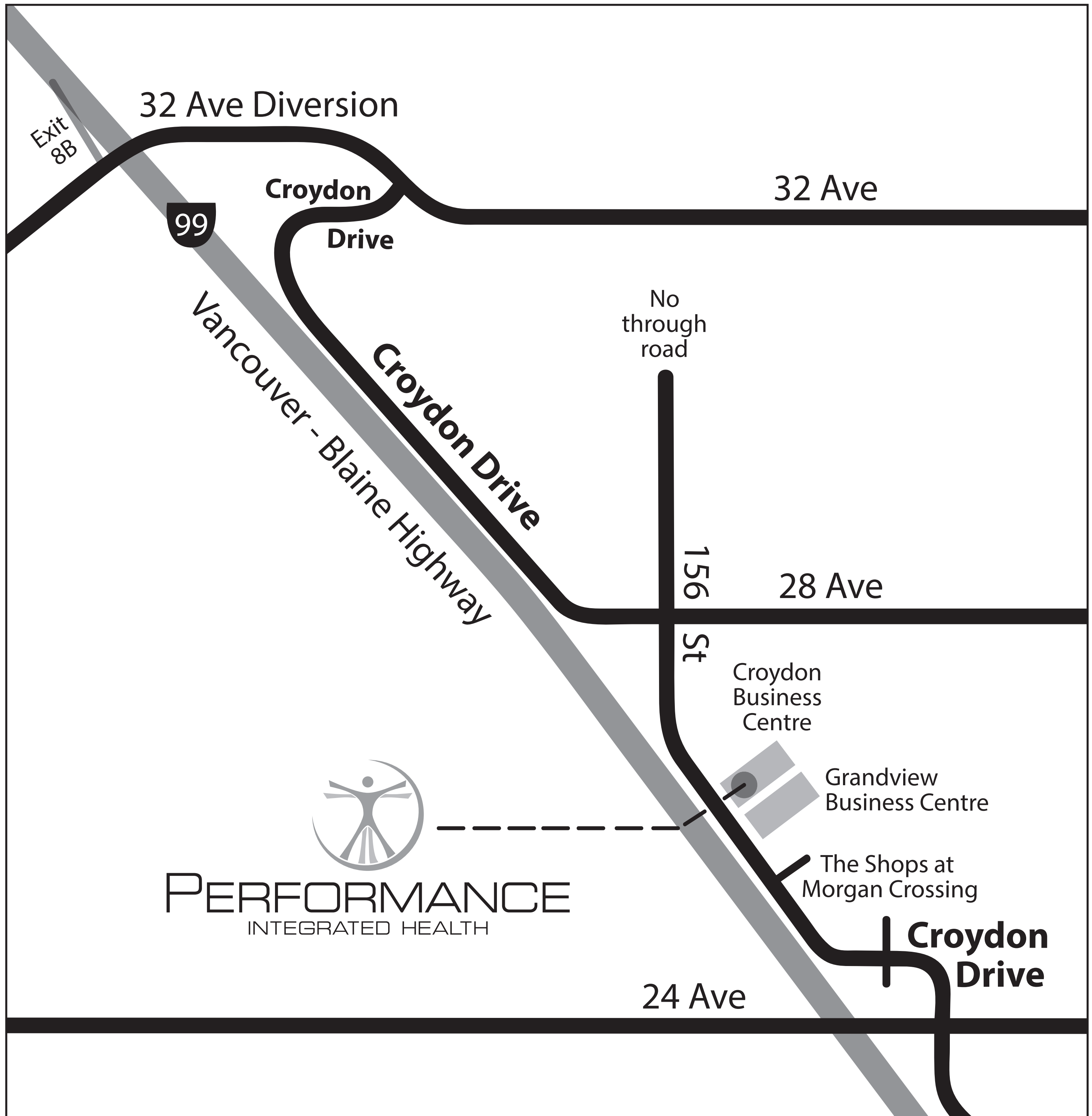
Dated this ______ day of ________________________ ,20______

Patient or Legal Guardian's Signature	Witness of Signature
Name	Name
(please print)	(please print)

Performance Integrated Health is in the Croydon Business Centre.

120 - 2630 Croydon Drive South Surrey BC V3Z 6T3 T 604 535 7705

There is parking directly in front of our offices.



From the North (32 Ave):

Follow Croydon Drive until you reach the intersection with 156 St (where there is a 4-way Stop sign). Turn right, drive round the left bend and you're there.

From the South (24 Ave):

Stay on Croydon Drive until you drive past the two entrances to Morgan Crossing shopping centre and you will soon approach us at the Croydon Business Centre.