ACUPUNCTURE/CUPPING
INITIAL INTAKE FORM

CLIENT NAME:

Anna Totzke R.Ac

TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

Please take a few moments to fill out this questionnaire carefully. All answers will be held strictly confidential. If you have any questions, please feel free to ask.

First Name: _____ Last Name: _____ Sex: M / F Age: _____
Address: _____ City: _____ Postal Code: _____
Home Phone: (_____)_____ Work Phone: (_____) _____
Email: _____ Date of Birth:_____Occupation: _____
Family Physician: _____ Phone No.: (_____) _____
Address: _____ City: _____ Postal Code:
How did you find us? Referred by:_____ □ Media □ Ad □ Street signs □ Other

Personal and Family Medical History

Check those that apply:	**Yourself**	Mother	Father	Grandparents	Brother	Sister	Children
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer (note type)							
COPD / Emphysema							
Depression							
Diabetes							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
Hepatitis							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Mental Illness							
Headaches							
Pneumonia							
Stroke							
Thyroid disorder							
Tuberculosis							
Ulcers							
Other							

List any surgeries that you've had (Include the year of the surgery): _____

_____

_____

_____

ACUPUNCTURE/CUPPING
INITIAL INTAKE FORM

CLIENT NAME:

Anna Totzke R.Ac

TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

Please list all medications and supplements you are taking, including length of use:

Medications (please give name, dose and amount of time on med)

Med _____ Dose_____ Length of use? _____
Med_____ Dose_____ Length of use? _____
Med_____ Dose_____ Length of use? _____
Med_____ Dose_____ Length of use? _____

Supplements/Vitamins/Herbs

Name/brand_____ Dose_____ Length of use? _____
Name/brand_____ Dose_____ Length of use? _____
Name/brand_____ Dose_____ Length of use? _____
Name/brand_____ Dose_____ Length of use? _____

Inquiry

Chief Complaint: _____

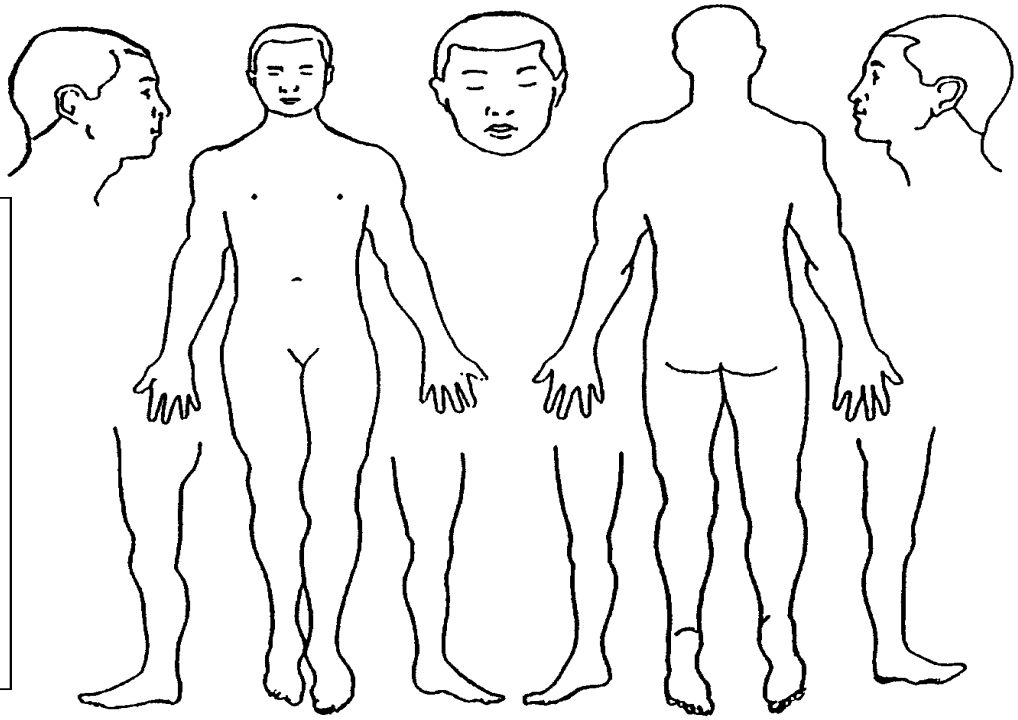
_____

History of the Present Disease

Onset of present condition: _____

Diagnosis by family physician: _____

Location of pain and discomfort:



Symbols

Pain/pressure	X
Swelling	⌒
Tension	+
Weakness	–
Pulsing	✳
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑

ACUPUNCTURE/CUPPING
INITIAL INTAKE FORM

CLIENT NAME:

Anna Totzke R.Ac

TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

Pain:

1 2 3 4 5 6 7 8 9 10 (1 = Minimal pain, 10 = Extreme pain)

- ❑ Dull
- ❑ Lingering
- ❑ Sharp
- ❑ Burning
- ❑ Stabbing
- ❑ Distending
- ❑ Contracting
- ❑ Aggravated / Alleviated by:

Pressure Temp Climate _____

Head and Body:

- ❑ Headaches
- ❑ Migraines
- ❑ Body aches
- ❑ Joint pain
- ❑ Neck pain
- ❑ Back pain
- ❑ Low back pain
- ❑ Muscle pains
- ❑ Weak limbs
- ❑ Numbness
- ❑ Heaviness
- ❑ Stiffness

_____
_____
_____

Cold and Heat:

- ❑ Tidal Fever
- ❑ Cold
- ❑ Cold hands/feet
- ❑ Cold back
- ❑ Chills
- ❑ Heat
- ❑ Clammy hands/feet
- ❑ Fever

_____
_____

Sweating:

- ❑ Spontaneous
- ❑ With exertion
- ❑ No sweating
- ❑ Hot flashes
- ❑ Local sweats
- ❑ Night sweats

_____
_____

Energy: 1 2 3 4 5 6 7 8 9 10 (1 = Minimal energy, 10 = Maximal energy)

- ❑ Fatigue
- ❑ Fatigues easily
- ❑ Sudden energy drop
- ❑ Dizziness
- ❑ Excess
- ❑ Drowsy
- ❑ Dyspnea / SOB
- ❑ Fainting
- ❑ Heavy feeling

_____
_____

Sleep: _____ Hrs/night

- ❑ Sound, restful
- ❑ Insomnia
- ❑ Heavy sleep
- ❑ Dream disturbed
- ❑ Not restful
- ❑ Grinds teeth

_____
_____

Urine:

- ❑ Normal
- ❑ Polyuria
- ❑ Urgency
- ❑ Incontinence
- ❑ Nocturia
- ❑ Infrequent
- ❑ Dysuria
- ❑ Hematuria
- ❑ Clear
- ❑ Dark
- ❑ Excess
- ❑ Scanty

_____
_____

Stool:

- ❑ Regular
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loose/watery
- ❑ Foul smell
- ❑ Gas
- ❑ Dry, hard
- ❑ Burning
- ❑ Explosive

_____
_____

ACUPUNCTURE/CUPPING
INITIAL INTAKE FORM

CLIENT NAME:

Anna Totzke R.Ac

TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

Thirst:

Thirsty w desire	Likes cold drinks	Dry mouth	_____
Thirsty w no desire	Likes hot drinks	Bitter taste	

Appetite: 0 1 2 3 4 5 (0 = No appetite, 5 = Heavy)

Cravings	Vomiting	Heartburn	_____
Abdominal cramps	Gas	Bad Breath	
Nausea	Bloating	Food Preferences	_____

Emotions:

Calm/relaxed	Angry	Grief	_____
Depressive	Irritable	Overthinking	
Anxious	Stressed	Fearful	_____

Lifestyle and Body Type:

Smoking	Irregular hours	Alcohol
Weight gain / loss	Shift work	Caffeine
Thin / Heavy	Regular Exercise	Occupational stress factors: _____

Eyes:

Blurry vision	Yellown	Spots in front of	_____
Poor vision	Dry eyes	eyes	
Eye pain	Burning	Red	_____

Ears:

Poor Hearing	Tinnitus	Earaches	_____

Skin and Hair:

Rashes	Ulcerations	Dandruff	_____
Itching	Eczema	Hair loss	
Dry skin	Hives	Changes in hair	_____

Gynecology:

Regular	Clots	Discharge:	_____
Irregular	Heavy / Light flow	PMS	
Amenorrhea	Pale / Dark colour	Pain	_____

Age at first period: _____ Age at menopause: _____ Number of Pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last period: _____

Oral contraceptive use: _____ Type: _____ For how long: _____

ACUPUNCTURE/CUPPING
INITIAL INTAKE FORM

CLIENT NAME:

Anna Totzke R.Ac

TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

Informed Consent for Acupuncture Treatment

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the options for and methods of therapy, techniques used, and duration of therapy. If you have questions about your treatment, please ask your attending Acupuncturist to further explain it all pertinent information's in regards to your Acupuncture treatment. You may also seek a second opinion from another health care professional, or terminate therapy at any time.

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of a Registered Acupuncturist on me by the Anna Totzke a Registered Acupuncturist.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping therapy, moxibustion, acupressure, qi gong, and traditional Chinese medicine counseling, and Chinese exercise therapy.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is an also common side effect of cupping therapy. Anna Totzke R. Ac uses sterile disposable needles and maintains a clean and safe environment.

I understand that a minority of patients may notice stiffness or soreness after the first few days of treatment by Tuina-Chinese manual therapy. I understand and am informed that, as in the practice of acupuncture and in the practice of there are some risks to treatment, including but not limited to strains, bruising and local pain. **Also, I will notify the Acupuncturist who are caring for me if I am or become pregnant.**

I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the Acupuncturist to exercise judgment during the course of treatment which the Acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of the Acupuncture therapy and procedures, and have had an opportunity to ask questions. 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 from A. Totzke.

Parents/Guardians I agree that I am solely responsible for the safety of my child/children while on the premise of TouchStone Health. Children are to be supervised at all times and never left unattended by the parent.

Patient's Name _____

Patient's Signature_____ **Date Signed** _____

ACUPUNCTURE/CUPPING
INITIAL INTAKE FORM

CLIENT NAME:

Anna Totzke R.Ac

TouchStone Health
564-572 Weber Street North, Unit 3A
Waterloo, Ontario
N2L 5C6

Fees, Insurance and Payment Agreement

The fees charged in our clinic are comparable to those charged by other specialists with similar qualifications in this geographic area.
The fees for the clinical services are payable at the time of the visit. For your convenience, we accept cash, personal cheques, or email transfers.
If you carry extended health insurance covering for any service that we offer, we will provide you with the necessary invoices for you to receive reimbursement.

Cancellation Policy

At our clinic, we all believe in respecting time. We will always do our best to prevent you from waiting before your appointments and/or having to change your appointments. We ask that, in return, you also respect our time. Please kindly give 48 hours notice if you need to change your appointment so another client can utilize that time slot. We reserve the right to charge full price for less then 48 hours cancellations and missed appointments (“no shows”.)

Please sign below indicating that you have read the policy and agree to its terms.

Name: _____