Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Acupuncture/ Auricular Acupuncture Intake Form

First Name: _____ Last Name: _____

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

City:_____ Postal Code:_____ Phone: _____ Cell: _____

Emergency Contact. _____

Email: _____ Occupation: _____

How did you hear of Visionary Health? _____

Please list your health concerns: _____

Are you currently being treated by any other physician(s) or healthcare practitioners?

_____

HEALTH HISTORY:

Height: _____ Current Weight: _____ Approx. weight 1 year ago: _____

Blood type: A □ B □ AB□ O□

Allergies: (please list any know allergies including medications, environmental & food related)

_____

Medications: (please list all prescription and non-prescription medications including birth control, aspirin, etc.)

_____

_____

Supplements: (please list vitamins, minerals or other natural supplements your are taking, with doses if known)

_____

Accidents/injuries/hospitalizations/surgeries (date and type): _____

_____

Do you suffer from any bleeding or clotting disorders? ? Yes □ No □ If yes, Please describe: _____

_____

Do you bruise easily? Yes □ No □

Have you recently, or are you currently taking any blood-thinning substances (Pharmaceutical or natural)? Yes □ No □

If yes, please list with the dosages: _____

Please indicate any adverse reactions you may have had to past cosmetic procedures if applicable:

_____

Immunizations: (please check any immunizations you have had and note any reactions)

□ Diphtheria, Pertussis, Tetanus, Polio, Hib
□ MMR (measles, mumps, rubella)
□ Influenza (Flu shot)
□ Hepatitis A and/or B
□ HPV (Gardasil)
□ Others (please list):

_____
_____
_____
_____

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Family Medical History: (please check areas pertaining to blood relatives NOT including yourself)

□ Alcoholism
□ Asthma
□ Anxiety
□ Arthritis
□ Cancer
□ Diabetes
□ Depression
□ Eating disorder
□ Epilepsy
□ Hay fever/allergies
□ Heart disease/stroke
□ Herpes
□ High Blood pressure
□ Kidney Disease
□ Liver Disease
□ Mental Disorder
□ Neurological disorder
□ Obesity
□ Substance Abuse
□ Thyroid problems
□ Others (Please list):

_____

_____

_____

Life Style:

	Daily	Weekly
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____
Coffee/Caffeine	_____	_____
Dairy	_____	_____
Exercise	_____	_____
Meditation	_____	_____
Sweets	_____	_____
Other	_____	_____

Are there any foods/food groups you avoid? _____

Blood
□ Anemia
□ Easy bruising/bleeding
□ Clots/thrombosis/DVT
□ Other_____

Endocrine
□Thyroid Conditions
□ Heat or cold intolerance
□ Blood Sugar Irregularities
□ Easy weight Gain
□ Other _____

Digestion
□ Daily bowel movements
□ Trouble swallowing
□ Heartburn
□ Abdominal pain
□ History of parasites
□ Change in thirst or appetite
□ Nausea and/ or vomiting
□ Loose stools or diarrhea
□ Constipation
□ Blood or mucus in stools
□ Diverticulosis
□ Belching or gas/ Bloating
□ Gall bladder disease
□ Hemorrohoids
□ History of eating disorder
□ Other _____

Neurological
□ Fainting or seizures
□ Numbness/tingling/paralysis □ Memory loss
□ Other _____

Emotional
□ Depression
□ Mood swings or mood disorders
□ Anxiety/nervousness
□ Other _____

Musculoskeletal
□ Joint pain or stiffness
□ History of broken bone(s)
□ Muscles spasms/cramps/weakness
□ Neck/back pain
□ Difficulty chewing, jaw clicking
□ Other _____

Female
Pregnant: Yes □ No □ Maybe □
Date of Last Pap: _____
□ History of abnormal pap(s)
□ Abnormal discharge
□ Sexual difficulties
□ Low libido
□ History of sexually transmitted infections
Age menses began: _____
# of pregnancies: _____ Births: _____
# of miscarriages/abortions _____
□ If menopausal, check here and skip the rest of the section
□ Regular cycles
□ Bleeding between periods
□ Menstrual Cramps
□ Excess Flow
□ PMS
□ Attempting Conception
□ Infertility
Date of Last period: _____
Length of complete cycle: _____
Days of flow: _____

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Breast(male and female)
□ Regular self-exams
□ Lumps/pain or tenderness
□ Discharge
□ Other _____

□ Hernia/testicular mass or pain
□ Regular Self-testicular exam
□ Sexual difficulties
□ Prostate problems
□ Sexually transmitted infections
□ Discharge or sores
□ Difficulty stopping or starting urination
□ Decreased flow or force of urination
□ Other _____

General
□ Night Sweats
□ Fatigue
□ Sleep disturbance
□ Dizziness
□ Stress
□ Exposure to Toxic chemicals

Skin
□ Rash/hives
□ Infections/fungus/athletes' foot
□ Dryness/scaling
□ Hair/nail Changes
□ Moles/growth
□ Other _____

Mouth and Throat
□ Sore throat/hoarseness
□ Mouth sores/Gum Problems
□ Dental Problems
□ Silver/Mercury fillings
□ Root Canal(s)
□ Loss of sense of taste
□ Other _____

Eyes/Ears
□ Recent change in Vision
□ Redness/itching of eyes
□ Eye pain, tearing or dryness
□ Ringing in the ears
□ Ear infection
□ Other _____

Head
□ Headache/migraine
□ Head injury
□ Other _____

Nose and Sinuses
□ Sinus problems/congestion
□ Nosebleeds
□ Loss of smell

Male
Urinary
□ Painful urination
□ Excessive urination
□ Frequency at night
□ Inability to hold urine
□ Bladder/kidney infection(s)
□ Blood in urine
□ Other _____

□ Frequent colds
□ Hay fever/Rhinitis/ congestion

Respiratory:
□ Cough
□ Difficult or painful breathing
□ Shortness of breath
□ Asthma
□ Bronchitis
□ Positive TB Test
□ other _____

Cardiovascular
□ Angina
□ High blood pressure / stroke
□ Murmurs
□ Chest Pains
□ Ankle Swelling
□ Palpitations, Fluttering, Irregular beat
□ Poor circulation
□ other _____

Sleep:
□ Do you feel refreshed upon waking
□ Do you have difficulty falling or staying a sleep
How many hours do you sleep on average? _____

Bowel Movements:
How many Bowel movements so you have a day/week ?_____
Is there blood or mucus in your stools?_____
Are there any undigested foods in your stool? ___

Please list the foods you eat on a regular day:

_____
_____
_____
_____

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INFORMED CONSENT- Acupuncture

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment. *If you refuse any special procedure this will not affect your receiving other care or future treatments.*

- This statement of consent pertains to the practice of acupuncture performed by Patricia Chen (Registered Acupuncturist) or Marina Kresovic (Auricular Acupuncture) at 5359 Dundas St West Unit 108, Toronto, Ontario, M9B 1B1.
- Acupuncture is a complete modality of diagnosis and treatment. Acupuncture treats the central nervous system rather than meridians.
- The practitioner inspects the ear for changes in shape, color, tenderness, and electrical conductance that signify pain, illness or any other pathological change. The points are then treated with a needle, ear seed, laser or electrical stimulation.
- Patients with high blood pressure should consult their medical or naturopathic doctor before beginning auricular acupuncture treatments.
- If you are currently pregnant or think you may be pregnant please let the practitioner know. While acupuncture is safe during pregnancy there are certain points that must be avoided.
- I understand that there may be some health risks with treatment from Acupuncture. These include, but are not limited to: possibility of bruising, minor bleeding, skin irritation and/or muscle discomfort.
- I understand that neither treatment outcomes, nor how long the effects can last, can be predicted.
- I understand that Acupuncture and Massage visits are separate services, and that Acupuncture treatment with Patricia Chen or Marina Kresovic, does not constitute a Massage visit.
- I understand that by law, Patricia Chen or Marina Kresovic is not able to discuss or prescribe treatments for any medical conditions or concerns during Acupuncture visits.
- I understand that any nutritional or natural supplements that are suggested during acupuncture treatments are general recommendations that pertain to skin care.
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.
- I understand that there is payment for today's treatment, and subsequent follow-ups, at the time of service accordingly to the fee schedule.
- I understand that a phone consultation fee may apply.
- A Missed Appointment Fee of $50 will be charged to your credit card for any missed appointments or cancellations within 24 hours of the appointment. All outstanding invoices will need to be paid before the appointment.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I give consent and authorize Visionary Health Medical Educational Clinic's practitioners to be contacted in the near future, for continued treatment.
- I understand that in the event there is a chance that media, audio or visual or published information could happen, all of which I am consenting that Visionary Health Medical Educational Clinic be able to use all various forms of social media.
- I authorize Visionary Health Medical Educational Clinic team to contact me for educational events, promotions, incentives, newsletters, engagements or information regarding of any health benefit.
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name (please print): _____

Patient Signature: _____Date: _____