monica patt
ACUPUNCTURE

10118a 124 Street
Edmonton, Alberta T5N 1P6
780.705.0444

New Patient Consultation Form Date of Consult:____/_____/_____ (m/d/y)

Patient Information

Name: DOB(m/d/y): Age:

Address: City: Postal Code:

Phone #: Email:

Height: Weight:

Emergency contact name: E.C. Phone number:

Primary Concerns:

1.

2.

3.

Operations and Hospitalizations

Date	Diagnosis	Procedure

Current use of Medication and Supplements (including vitamins and herbs)

Name	Dose/Frequency	Reason for use

Allergies (Including Medication & Environmental Allergies)

Drug or Substance	Reaction

Family Medical History

Check if Applicable	Mother	Father	Brother	Sister	Child
General Health	☐ Good ☐ Poor	☐ Good ☐ Poor	☐ Good ☐ Poor	☐ Good ☐ Poor	☐ Good ☐ Poor
Cancer	☐	☐	☐	☐	☐
Diabetes ☐Type 1 ☐ Type 2	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
☐Hypertension ☐Hypotension	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Seizures/Stroke	☐	☐	☐	☐	☐
Other: _____ _____	☐	☐	☐	☐	☐

Past Medical History:

(Check any of the following conditions you have or have had in the past)

☐Heart Disease	☐Asthma	☐Diabetes	☐Ulcers	☐Chicken Pox
☐Stroke	☐Emphysema	☐Appendicitis	☐Colitis	☐Measles
☐ Arteriosclerosis	☐Pneumonia	☐Polio	☐Gastritis	☐Mumps
☐Pacemaker	☐Tuberculosis	☐Seizures	☐IBS	☐Rheumatic Fever
☐Anemia	☐Bronchitis	☐Epilepsy	☐Gout	☐Scarlet Fever
☐Hypertension	☐Pleurisy	☐Cancer	☐Goiter	☐Mononucleosis
☐Hypotension		☐Multiple Sclerosis	☐Alcoholism	☐Hepatitis _____
				☐Herpes
☐Hypothyroid	☐Osteo-arthritis			☐AIDS/HIV
☐Hyperthyroid	☐Rheumatoid Arthritis			☐Birth Trauma

Lifestyle:

☐ Alcohol,_____(#)/week ☐ Marijuana,_____(#)/day ☐Other,_____(#)/day

☐ Tobacco,_____(#)/day ☐Soft drinks,_____(#)/day

☐Coffee,_____(#)/day Exercise: ☐yes ☐no _____times/week

☐ family stress ☐work stress

Dietary Information:

☐ poor appetite	☐ crave sweet	☐ bitter taste in mouth	☐ no thirst
☐ normal appetite	☐ crave salt	☐ metal taste in mouth	☐ very thirsty
☐ excessive appetite	☐ other cravings:	☐ sweet taste in mouth	☐ normal thirst
☐ prefer warm beverages		☐ sour taste in mouth	# of glasses of water/day _____
☐ prefer cold beverages		☐ other taste in mouth:	

Average Daily Menu:

Breakfast

_____

_____

Lunch

_____

_____

Dinner

_____

_____

Snacks throughout day

_____

Sleep:

☐ Insomnia ☐Problems staying asleep ☐ Dream disturbed sleep ☐Hours of sleep per night _____ hours

☐Waking up tired ☐ Troubles falling asleep ☐Nightmares

Cardiovascular:

☐ High Blood Pressure ☐ Lightheaded ☐ Slow heartbeat ☐ Heart Attack

☐ Low Blood Pressure ☐Fainting ☐ Fast heartbeat ☐ Phlebitis

☐ Irregular Heartbeat ☐Chest Pain ☐ Heart Palpitations ☐ Blood Disorder

Respiration:

☐Shortness of Breath ☐Asthma ☐Dry Cough

☐Tightness in Chest ☐History of Bronchitis ☐Coughing Blood

☐Difficulty Breathing Laying Down ☐History of Pneumonia ☐Productive Cough with Phlegm Color of Phlegm:

☐Chronic Cough

Gastrointestinal:

☐Nausea
☐Vomiting
☐Acid Regurgitation
☐Diarrhea
☐Constipation
☐Gas
☐Hiccup
☐Bloating after meals
☐Stomach Cramping
☐Intestinal cramping
☐Bad Breath
☐Laxative Use
☐ Gastritis
☐Hard Stools
☐Black stools
☐Mucus in stools
☐Loose stools
☐Blood in stools
☐Undigested food in stools
☐Itchy Anus
☐Burning Anus
☐Rectal Pain
☐Ulcerative Colitis
☐Hemorrhoids
☐Irritable Bowel Syndrome

_____(#) bowel movements/day

Eyes, Ears, Nose, Throat, Head:

☐Glasses
☐Eye Strain
☐Poor/Blurred Vision
☐Night blindness
☐Red Eyes
☐Itchy Eyes
☐Spots in Eyes
☐Cataracts
☐Glaucoma
☐Poor Hearing
☐Tinnitus/Ringing in Ears
☐Earaches
☐Nosebleeds
☐Headaches
☐Migraines
☐Concussions
☐Sinus Problems
☐Recurrent Sore Throat
☐Dry Mouth
☐Excessive Saliva
☐Clear throat often
☐Other:
Grinding Teeth
☐TMJ
☐Bleeding Gums
☐Sores on lips or tongue

Skin & Hair:

☐Rashes
☐Hives
☐Ulcerations
☐Psoriasis
☐Dry Skin
☐Oily Skin
☐Itchy Skin
☐Eczema
☐Shingles
☐Fungal Infections
☐Acne
☐Premature Grey Hair
☐Alopecia/Hair Loss
☐Dry Brittle Hair
☐Dandruff

Genito-urinary:

☐Painful Urination	☐Frequent Bladder Infections	☐Urinary Incontinence	☐Blood in Urine
☐Frequent Urination	☐Frequent Kidney Infections	☐Retention of Urine	
☐Burning Urination	☐History of Kidney Stones	☐Urination at Night	

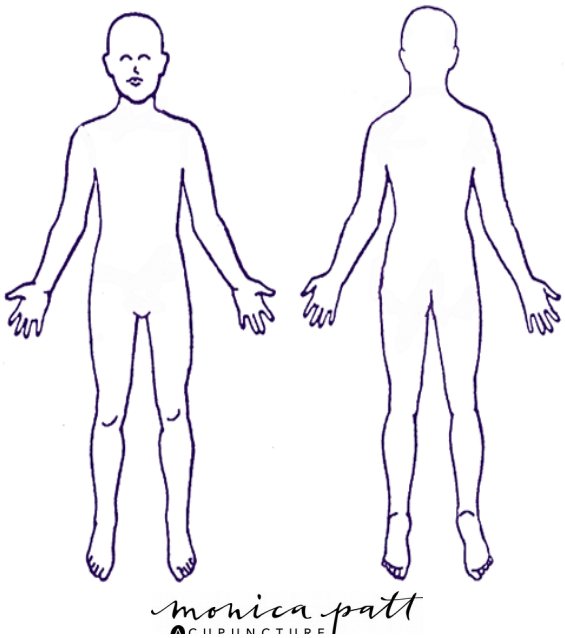
Neuropsychological:

☐Numbness	☐Poor Memory	☐ADHD	☐Parkinson's
☐Tingling	☐Easily Stressed	☐Abuse Survivor	☐Bell's Palsy
☐Tics/Tremors	☐Irritability	☐Anxiety	☐Trigeminal Neuralgia
☐Seizures	☐Fainting	☐Depression	

Musculoskeletal:

☐Neck/Shoulder Pain	☐Upper Back Pain	☐Joint Pain	☐Limited Range of Motion
☐Muscle Pain	☐Lower Back Pain	☐Limited Use Other (describe):	

Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain). Please indicate if there is numbness, tingling or radiating pain.



Consent to Treatment

I, the undersigned, do hereby voluntarily consent to be treated with acupuncture including modalities such as cupping, electro-acupuncture, moxibustion, gua sha and herbal therapy, administered by Monica Patt, R.Ac HHP or Christina Pistotnik, R.Ac, 10118 A 124 Street Edmonton, Alberta T5N 1P6.

Services are a supplement to and not a replacement for standard medical care.

I understand that acupuncture is performed by the insertions of fine, pre sterilized, disposable, stainless steel needles into the skin. Acupuncture regulates various physiological functions in the body and stimulates the body's natural ability to heal. Acupuncture has been used safely for centuries as a natural, drug free approach to wellness.

I have been made aware that certain adverse side effects may result. This could include, but not limited to some local bruising, minor bleeding, temporary pain or discomfort, possible temporary aggravation of symptoms, dizziness or fainting.

Clients are free to stop acupuncture at anytime. No guarantees concerning its use and effects are given.

I understand all of my records will be kept confidential and will not be released without my written consent.

Cancellation Policy:
Please note, we do require at least 24 hours notice for full appointment cancellations.

Last minute, same day cancellations and missed/no show appointments will result in full charge of 100% of treatment cost at $90.

Direct Billing Insurance Policy:

I understand that it is my responsibility for the payment of services rendered at Monica Patt Acupuncture. If my claim is submitted directly to an outside agency for payment and for some reason the third party payer, such as but not limited to extended health benefits from my employer, denies the claim and or/refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding at the time of treatment.

Initial Consultations and Treatment- $130 Follow Up Treatments $90

Please sign and date below to indicate you have read and understood this form.

Client Name (printed) _____

Signature of Client: (or guardian if under 18): _____

Date Signed: _____