**Guiomar Campbell R.Ac. Registration CTCMPAO#2028 110 Eglinton Ave. East, Suite 502**

**Acupuncture & Traditional Chinese Medicine**

**Disclosure Statement & Informed Consent**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby request and consent to Acupuncture and any form of Traditional Chinese Medicine treatments (Cupping, Gua Sha, Massage, Moxabustion) for my stated health concern.

I have been informed that acupuncture is a safe method of treatment, however one may

experience some discomfort including pain, dizziness, bruising, or numbness. Unusual and

rare risks of acupuncture include nerve damage, organ puncture, infection, premature birth, or

miscarriage. Other side effects and risks may also occur. If I suspect I am pregnant, I will

inform Guiomar Campbell immediately. I also authorize this consent form to cover the duration of my treatments with Guiomar Campbell.

I have discussed the nature and purpose of my treatment with my practitioner and understand

there are no guarantees regarding cure or improvement of the condition. I understand there

may be limitations to the treatment and may referred to another practitioner or health care

provider that will benefit my treatment if necessary. I understand that I also have the choice to

stop, change or modify my treatment plan.

**PRIVACY:** All information discussed is strictly confidential, in accordance to the Personal

Health Information Protection Act (“PHIPA”) of Ontario.

**INSURANCE** Guiomar Campbell does not bill insurance for you. We will provide you with a receipt for your insurance company upon request.

**APPOINTMENTS:** All appointments that are cancelled with less than 24 hours notice and

missed will be charged $65.00. I as the client agree to pay in full for all of my Acupuncture

treatments.

I have read or have had read to me the above consent. I also have had the opportunity to

clarify any questions about the content. By signing below, I agree to all terms and conditions

stipulated by this document. I am aware this form will cover the entire course of treatment for

my condition, and any further condition(s) treated with Guiomar Campbell.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for booking acupuncture with Guiomar at Thrive**

**Please review the points below to prepare you for your first visit:**

 Your first session, including the intake, assessment and treatment will take approximately 100min

 You are covered during your acupuncture treatment. We can work around

the clothing you come in, but please bring shorts and a t-shirt or tank top if possible.

 Please try to eat before your acupuncture appointment but small amount. An empty stomach is not ideal for acupuncture.

 Please be respectful of your booking. If you are going to be late, please let us know by

calling or texting **647 352 7911.** There is also a 24-hour cancellation fee of **$65.00** for

missing your appointment.

 After your treatment, it’s best to have a relaxing day/evening and avoid coffee, alcohol,

dairy, sugar or stressful situations and to sleep at a reasonable hour.

**Directions to Thrive Natural Family Health:**

Contact info

Guiomar Campbell R.Ac. Acupuncturist
Thrive Natural Family Health **110 Eglinton Ave. East, Suite 502**

Get off Eglinton/Yonge subway station and walk East two blocks. The clinic is located in the North side of Eglinton

guia@thrivehealth.ca

647 352 7911

**Initial Patient Intake Form**

**PLEASE NOTE:** If you come across any questions that may be confusing or you do not currently have information for, please highlight them. Take your time, feel free to use additional writing space, and answer the following questions to the best of your ability. Thank you.

**Basic Contact Information:**

Today’s Date (MM/DD/YY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identification:\_\_\_\_\_\_\_Date of Birth (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of Years in Canada:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Living Arrangement (single, married, children etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Hours/Week Worked:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician Name & Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is their relation to you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about this clinic?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance that covers Acupuncture?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Health Concern Information:**

What is your Main Health Concern?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it begin?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was there a specific event that initiated it? (accident, illness etc.), Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information:**

Do you have any children? If so, how many?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently, or have you ever smoked? If so, for how long?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink coffee? If so, how many per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? What kind? And how often?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any operations you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you even been hospitalized? Please explain the conditions:

Please list any western medications/prescription drugs you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any diagnosis from a Western Medical Doctor? (e.g. low iron, high blood pressure etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any supplements/vitamins you are taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your diet like:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Overall Body Evaluation: (Please check ALL that apply.)**

**WOOD ELEMENT (LIVER/GALLBLADDER)**

\_\_\_\_\_ Headaches \_\_\_\_\_ Migraines \_\_\_\_\_ Pain in the Rib Areas \_\_\_\_\_ Cold Hands & Feet

\_\_\_\_\_Neck/Shoulder Tension \_\_\_\_\_ Stress \_\_\_\_\_ Grinding Teeth \_\_\_\_\_ Jaw Pain \_\_\_\_\_ Body Pains

**FIRE ELEMENT (HEART/SMALL INTESTINE)**

\_\_\_\_\_ Heart Palpitations \_\_\_\_\_ Anxiety \_\_\_\_\_ Nervousness \_\_\_\_\_ Difficult to Fall Asleep

\_\_\_\_\_ Wake up Often \_\_\_\_\_ Easy to Fall Asleep \_\_\_\_\_ Wake up Rested \_\_\_\_\_ Tired \_\_\_\_\_ Nightmares

\_\_\_\_\_ Vivid Dreams \_\_\_\_\_ Light Sleeper

How many hours of sleep do you get per night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EARTH ELEMENT (SPLEEN/STOMACH)**

\_\_\_\_\_ Gas \_\_\_\_\_ Bloating \_\_\_\_\_ Upset/Sensitive Stomach \_\_\_\_\_ Nausea \_\_\_\_\_ Acid Reflux

\_\_\_\_\_ Heartburn \_\_\_\_\_ Increase/Decrease in Appetite \_\_\_\_\_ Cloudy Headed/Heavy Headed

\_\_\_\_\_ Food Allergies If so, what are they?

**METAL ELEMENT (LUNG/LARGE INTESTINE)**

\_\_\_\_\_ Shortness of Breath \_\_\_\_\_ Pain in the Chest \_\_\_\_\_ Stuffy Nose \_\_\_\_\_ Runny Nose

\_\_\_\_\_ Frequent Colds \_\_\_\_\_ Eczema \_\_\_\_\_ Psoriasis \_\_\_\_\_ Acne \_\_\_\_\_ Sensitive Skin \_\_\_\_\_ Asthma

\_\_\_\_\_ Allergies If so, what are they? (environmental, seasonal etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WATER ELEMENT (KIDNEY/URINARY BLADDER)**

\_\_\_\_\_ Low Back Pain \_\_\_\_\_ Sensitive/Pain in the Knees \_\_\_\_\_ Sensitive/Pain in the Ankles

\_\_\_\_\_ Cold Low Back \_\_\_\_\_ UTIs/Bladder Infections

How many times a day do you urinate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you experience any of the following:**

\_\_\_ Burning with urination \_\_\_ Blood in the urine \_\_\_ Incontinence \_\_\_ Urgency with urination

\_\_\_ Cloudy urine \_\_\_ Urination at Night If so, how many times?

**BOWEL MOVEMENTS:**

How many bowel movements do you have a day? Do you experience constipation?

What is your stool generally like? Please check all that apply:

\_\_\_ Soft \_\_\_Loose \_\_\_ Diarrhea \_\_\_ Undigested Food \_\_\_ Blood in Stool \_\_\_ Mucus in Stool

**GYNECOLOGICAL:**

If you remember, please state the age of your first menses (period)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you experience any of the following:**

\_\_\_\_\_Clots \_\_\_\_\_ Painful Periods \_\_\_\_\_Breast Tenderness \_\_\_\_\_Endometriosis \_\_\_\_\_ Infertility

\_\_\_\_\_ Light Periods \_\_\_\_\_ Heavy Periods \_\_\_\_\_ PMS \_\_\_\_\_ Fibroids \_\_\_\_\_Cysts\_\_\_\_\_\_\_\_\_\_\_\_\_Other:

**OVERALL HEALTH:**

\_\_\_\_\_ Bleed/Bruise Easily \_\_\_\_\_ Blurry Vision \_\_\_\_\_ Blurry Vision at Night \_\_\_\_\_ Dry Skin / Hair / Nails

\_\_\_\_\_ Dizziness \_\_\_\_\_ Sweat Easily \_\_\_\_\_ Night Sweats

What is your overall body temperature? (more hot/more cold)

Do you feel thirsty/dry mouth? How much water do you drink a day?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What temperature of liquids do you prefer? (hot/cold/warm/room temp.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your appetite generally?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main food cravings?

**FAMILY MEDICAL HISTORY:**

Please state if **you or an immediate family member** has experienced any of the following conditions

:

\_\_\_ Diabetes \_\_\_ HIV/AIDS \_\_\_ Cancer \_\_\_ Arthritis \_\_\_ Asthma \_\_\_ Stroke \_\_\_ Menstrual Issues

\_\_\_ Seizures \_\_\_ Kidney Disease \_\_\_ Liver Disease \_\_\_ Hepatitis \_\_\_ Lung Disease

\_\_\_ Allergies \_\_\_ Thyroid Disease \_\_\_ Heart Complications \_\_\_ High/Low Blood Pressure

Other / Notes:

*Thank you for taking the time to complete this form.*