



## Dr Jackie Zhang DC, RAc

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# CONSULTATION ADMITTANCE FORM

## HEALTH HISTORY

(Please answer all questions, even if they seem unrelated to your case.)

Name: \_\_\_\_\_ AHC# \_\_\_\_\_ Date: \_\_\_\_\_

Ph: (H)  \_\_\_\_\_ (w)  \_\_\_\_\_ (C)  \_\_\_\_\_

(Check your preferred phone number above)

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(dd/mm/yyyy)

Age: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_ Children: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Sex:  Male  Female Title:  Mr.  Mrs.  Ms. Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Healthcare insurance? (Manulife, Blue, Cross, etc.) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph: \_\_\_\_\_

### How did you find out about us?

Healthcare provider  Lawyer  Employer  Clinic Materials

Special Event  Here Before  Website  Special Offer

Can Pages  Yellow Pages  Family/Friends  Signage

Radio  Other \_\_\_\_\_

Who referred you? \_\_\_\_\_

Present Complaints: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

What caused this condition? \_\_\_\_\_

Have you ever had this condition before? \_\_\_\_\_

Are your symptoms getting  better  worse  staying the same  constant  
 comes and goes

On a scale of 0-10 how severe is your pain? (0=no pain, 10=excruciating) \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is this work related?  Or a motor vehicle accident?  Date of Injury/accident \_\_\_\_\_

Are you here for treatment due to:  Surgery?  Fracture?  
 Date of occurrence? \_\_\_\_\_

Do you have pain or difficulties with your:  hip  leg  feet

**Please complete the following chart:**

<b>Prescription Medication</b> (Include Birth Control)	<b>Over-the-counter Medication</b> (e.g. Tylenol, Advil, etc.)	<b>Vitamins &amp; Supplements</b>

When was your last treatment?

Chiropractic \_\_\_\_\_ Physiotherapy \_\_\_\_\_ Massage \_\_\_\_\_ Acupuncture \_\_\_\_\_

Have you been treated for any health condition in the last year?

Yes  No If yes, list any upcoming/recent tests or surgeries

How important is your health to you on a scale of 1-10, 10 being most important?r any health condition in the last year? \_\_\_\_\_

Provide dates of **ALL** surgeries, fractures, and major illnesses:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List **ALL** motor vehicle accident dates and other major accidents or falls (please describe):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please ✓ and list any of the following devices that you currently wear or are implanted:

- Prosthetic devices \_\_\_\_\_
- Implants (pins/wires/artificial joint) \_\_\_\_\_
- Hearing aids \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Orthotics \_\_\_\_\_
- Heel lifts/inserts \_\_\_\_\_

Check ✓ any conditions which are presently causing you a problem.

Please underline conditions which were a problem in the past.

**GENERAL**

- headache
- migraines
- dizziness
- ringing in ears
- fainting
- earache
- sore throat
- nose bleeds
- sinus problems
- asthma
- enlarged glands
- unexplained weight loss
- hypoglycemia
- nervousness/anxiety
- depression/confusion
- vision problems
- dental problems
- hearing problems
- fever
- night sweats
- osteoporosis
- hyper/hypoglycemia

**ORGANS**

- frequent urination
- painful urination
- blood in urine
- bladder problems
- kidney stones
- bed wetting
- prostate problems
- sexual dysfunction
- anemia
- eating disorders
- thyroid problems
- excessive appetite
- gas / bloating
- nausea / vomiting
- constipation / diarrhea
- colitis/Chron's/IBS
- black / bloody stool
- hemorrhoids
- liver problems
- gall bladder
- rheumatic fever

**SKIN**

- eczema
- skin eruptions
- varicose veins
- rashes
- loss of sensation/pins and needles
- varicose veins
- sensitivity to tape/lotions
- contagious conditions

**MUSCLE & JOINT**

- neck problems
- whiplash
- upper back problems
- low back problems
- tailbone pain
- spinal curvature
- pelvic numbness and/or pins & needles
- limb problems
- walking problems
- arthritis
- rheumatoid arthritis
- sore joints
- sore muscles
- jaw problems

**RESPIRATORY & HEART**

- lung problems
- chronic cough
- spitting up blood
- frequent colds/flu
- difficult breathing
- heart problems
- swollen ankles
- high/low blood pressure

**FEMALES ONLY**

- painful periods/PMS
- irregular cycle
- cramps, backache
- vaginal discharge/infection
- lumps/pain in breast
- menopausal symptoms
- previous miscarriage
- unable to get pregnant
- hot flashes
- recent abortion/delivery

**Are you pregnant?**

- Yes  No  Not Sure

**When was your last period?**

Check any of the following diseases you have (or have had):

- alcoholism  HIV  Hepatitis  stroke  arthritis  heart disease  heart attack
- Sexually transmitted diseases  diabetes  cancer  nervous system disorder  
(eg. MS, CP, Parkinsons)
- allergies  Other

Has anyone in your family had any of the following diseases?

- heart disease  high blood pressure  cancer  stroke  arthritis  diabetes
- who \_\_\_\_\_ who \_\_\_\_\_ who \_\_\_\_\_ who \_\_\_\_\_ who \_\_\_\_\_ who \_\_\_\_\_

Do you experience any of the following symptoms:

- depressed mood  overwhelming sadness  high stress levels  heightened anxiety
- elevation mood  unmanaged pain levels  inability to sleep
- inability to focus on the task at hand

Do you currently need help managing:

- weight loss  diabetes  allergies  a vegetarian diet

Are you presently suffering from the following:

- tension headaches  teeth/jaw pain  bleeding of gums during brushing
- mouth sensitivity to pressure and/or temperature. When was the last time you had your teeth cleaned? \_\_\_\_\_

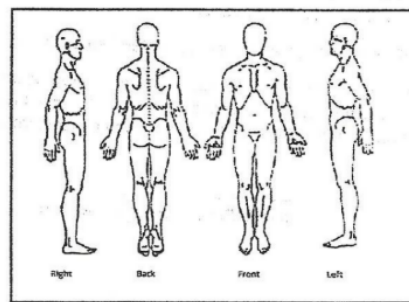
Please check any of the following that apply to you. Please use the options: none, light, moderate, or heavy to best describe how often you participate or how much you feel it represents you. For example, do you feel you are under a heavy amount of stress? Do you feel you only drink a light amount of coffee/tea a day (one cup)? Diseases you have (or have had):

LIFESTYLE	None	Light	Moderate	Heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee/Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

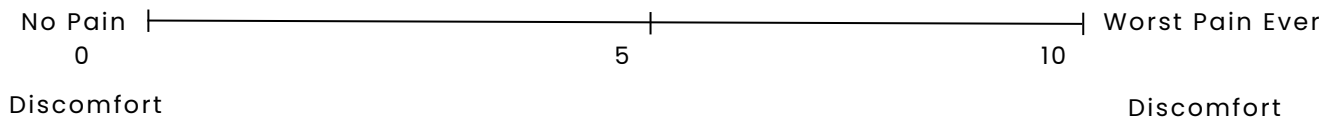
### Symptoms Diagram

Using the symbols below, please draw on the diagram below to indicate the symptoms you have been experiencing in the locations you are experiencing them. Please also draw a face on the diagram.

Numbness = 0000000000	Sharp/Stabbing ++++++	Shooting = SSSSSSSSS
Pins & Needles= *****	Ache/dull pain= ^^^^^^^	Tender= PPPPPPPPP



Indicate on the line how bad your pain or discomfort is.





# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

### **Benefits**

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

### **Risk**

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

### **Please inform the chiropractor if you:**

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

### **Pregnancy**

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

### **Alternatives**

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

**Questions or Concerns**

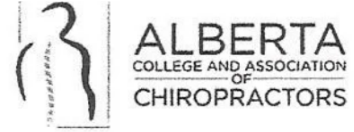
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have read this form and discussed with the chiropractor the assessment of my condition and the treatment plan. I Understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date

# COVID-19 screening questions



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

Individual being screened name: \_\_\_\_\_

Screened by: \_\_\_\_\_

**The following questions must be asked of patients and companions:**

Do you have current symptoms of COVID-19, such as:

Yes No

- a fever,
- a new or changed chronic cough,
- a sore throat that is not related to a known or preexisting condition
- a runny nose that is not related to a known or preexisting condition
- nasal congestion that is not related to a known or preexisting condition
- shortness of breath that is not related to a known or preexisting condition

Yes No

- Have you traveled internationally within the last 14 days?
- Have you had unprotected close contact with individuals who have a confirmed or presumptive diagnosis of COVID-19 (e.g. individuals exposed without appropriate PPE in use).

Answering YES to any of the above questions indicates that an individual is symptomatic of COVID-19, or may have been exposed to COVID-19. Individuals should be told to self-isolate and call HealthLink 811.

If the individual is a patient, they are not eligible for care at this time. If the individual is a practitioner or staff, they are not eligible for work at this time.