



Jennifer Foster, D.Ac., Acupuncture and Traditional Chinese Medicine

541 Palace Rd. Kingston, ON K7L 4T6  
613-547-KIHC (5442)  
www.kihc.ca

### ADULT INTAKE FORM

Every detail you provide will help you achieve your health goals and will remain confidential. Please bring this completed form to your first appointment, along with a signed Informed Consent form, Consent for Use of Personal Health Information form, and any relevant health reports.

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

Date of birth (dd/mm/yy): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Email address: \_\_\_\_\_

What is the best way for us to contact you? \_\_\_\_\_

May we leave telephone messages at home or work? \_\_\_\_\_

Would you like to receive our clinic email newsletter? \_\_\_\_\_

Emergency contact information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

How did you hear about this Traditional Chinese Medicine practice? \_\_\_\_\_

Please list all other healthcare practitioners you are seeing:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Please list your primary health concerns, in order of importance:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_

2. \_\_\_\_\_ Date of onset: \_\_\_\_\_

3. \_\_\_\_\_ Date of onset: \_\_\_\_\_

4. \_\_\_\_\_ Date of onset: \_\_\_\_\_



## MEDICAL HISTORY

Please list any hospitalizations, surgeries, traumas (including emotional traumas) or major illnesses:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Date Resolved: \_\_\_\_\_

Please list any **medications** you are taking, including antacids, pain medications, and laxatives:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_

Please list any **supplements** or vitamins you are taking:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_

Approximately how many times have you been treated with antibiotics? \_\_\_\_\_

Please list any allergies, sensitivities, or adverse reactions (e.g. to medications, immunizations, food, chemicals, pets):

## EMOTIONAL HEALTH

On a scale of 1 (low) to 10 (high), please rate your overall level of stress: \_\_\_\_\_

On a scale of 1 (low) to 10 (high), please rate your overall energy level: \_\_\_\_\_

On a scale of 1 (low) to 10 (high), please rate how happy you are generally: \_\_\_\_\_

How would you describe the emotional climate of your home? \_\_\_\_\_

Do you feel that your home is a safe place? \_\_\_\_\_

Do you have any concerns regarding your emotional or mental health (please describe)? \_\_\_\_\_



**LIFESTYLE**

How often do you consume the following:

Alcohol: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

Caffeine: \_\_\_\_\_ Water: \_\_\_\_\_ Tobacco: \_\_\_\_\_

Please describe what forms of exercise you participate in, and how often:

\_\_\_\_\_

What is your occupation? \_\_\_\_\_

Please list some of your hobbies: \_\_\_\_\_

**FAMILY HISTORY**

Please indicate whether the following health conditions **pertain to any of your family members:**

Condition	Relative	Age of Onset	Details
Heart problems (e.g. high blood pressure)			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Crohn's disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Diabetes			
Autoimmune disease			
Mental illness (e.g. depression)			
Difficulties with drugs and/or alcohol			
Other			

Is there anything else you would like to include on this form? \_\_\_\_\_

\_\_\_\_\_

*Thank you.*



## CONSENT TO TREATMENT WITH TRADITIONAL CHINESE MEDICINE

I consent to my treatment with acupuncture, Chinese herbal medicine, and other related procedures, such as moxibustion and cupping, as proposed by my health practitioner.

I understand that acupuncture treatment may produce side effects, including minor bleeding/bruising, minor pain/soreness, nausea, and fainting. I understand that discolouration of the skin may result from moxibustion or cupping procedures. I also understand that more serious, though rare, risks have been associated with acupuncture treatment, such as infection, organ perforation, bent or stuck needles, and seizure.

I understand that only disposable, sterilised needles will be used for my treatment and that these needles will be disposed of following the treatment, in accordance with internationally accepted protocols for safe needle techniques and handling.

I understand that the Chinese herbal medicines in the prescription recommended by my health practitioner are traditionally considered safe, although may become toxic in amounts that exceed the prescribed dose or inappropriate during pregnancy.

I confirm that I have shared all pertinent medical information with my health practitioner, including pregnancy and the prospect of pregnancy, communicable diseases and blood disorders, seizure disorder, prior surgeries and surgical implants, current and past medications (including blood thinners), and any other information that may increase the likelihood of risks associated with my treatment.

I understand that my health practitioner cannot anticipate and explain all possible risks and consequences of treatment, but am satisfied that my health practitioner has discussed with me the risks and benefits of the proposed treatment and that all my questions have been answered. I have read and understand the information contained within this form. My signature below indicates my informed consent to the proposed treatment.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



*Jennifer Foster, D.Ac., Acupuncture and Traditional Chinese Medicine*

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## CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern and the personal health information you disclose to Jennifer Foster during your appointments will be handled in accordance with current privacy legislation. Personal health information includes identifiable information such as age, gender, family status, and health history.

Jennifer Foster, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

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I have reviewed the above information and authorize Jennifer Foster, employees, and health practitioners of 541 Palace Road to collect, use, and disclose my personal health information as outlined above.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS