Westside General Intake Form

acacia health
health, through science & nature

Name_____ Pronouns_____ Birthdate_____
Address_____ City: _____Province_____
Postal Code_____ Phone (home)_____ Phone(work/cell) _____
Email _____Occupation_____full-time☐ part-time☐
Emergency contact _____Relation? _____
Emergency contact Phone_____ How did you hear about us? _____
Family doctor: _____Phone (if known): _____

Current Health Concerns

Reason for seeking treatment today (please include when and how it started)?

_____
_____

What makes the pain/symptoms better or worse? _____
_____
_____

Please list any and all medications you are currently taking (including dosage):

_____
_____
_____

Please list any supplements and/or herbs you may be taking:

_____
_____
_____

Your Health History

Please list any allergies you may have: _____
Are you pregnant? If so how far along are you? _____
Please list any surgeries you may have had performed (including all the different types and dates):

_____
_____
_____

Please list all past injuries (including all the different types and dates):

_____

_____

_____

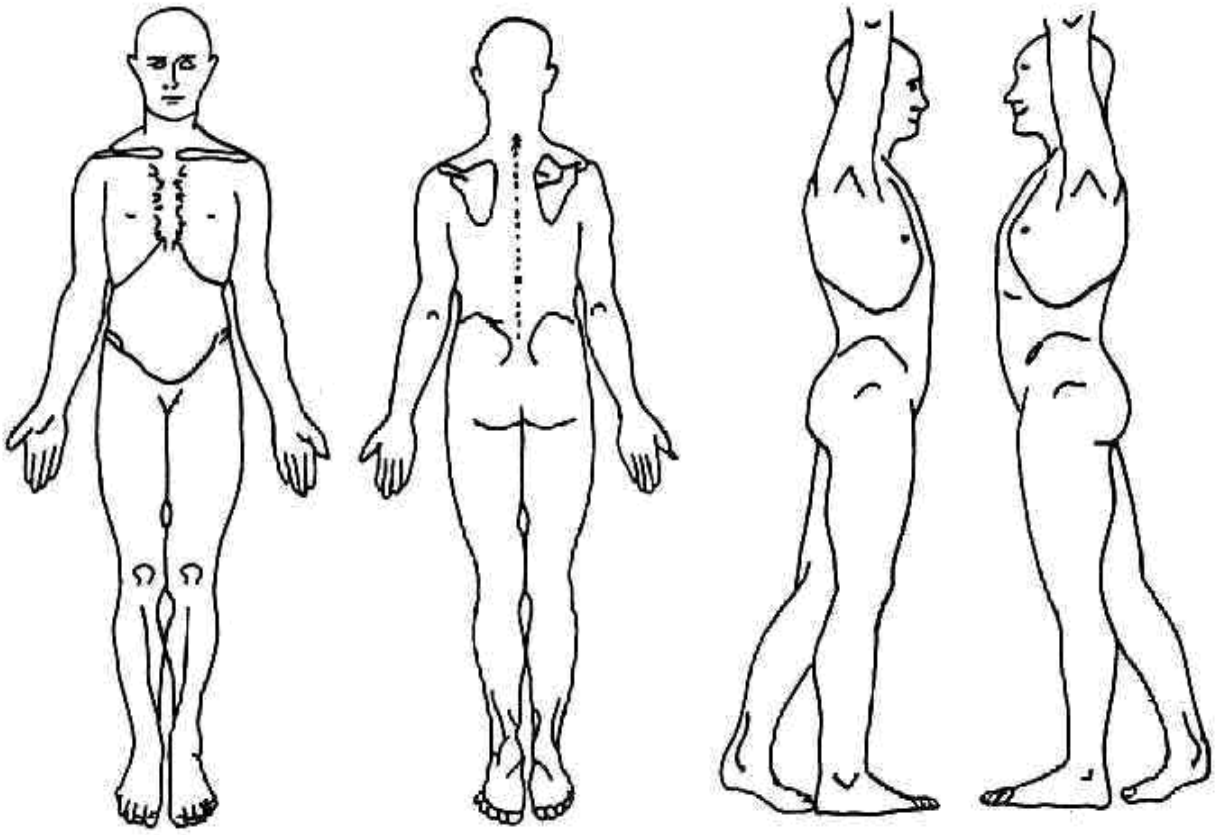
Please circle any conditions you have or have had in the past:

Conditions	Symptoms	Neurological	Genitourinary	Skin	Respiratory	Reproductive
• Migraines • Arthritis • Osteoporosis • Cancer • Infection • Heart Disease / Stroke • Diabetes • Mental Health Disorder • Depression • Hepatitis • Alcoholism	• Headache • Vertigo • Weight loss • Weight gain • Fever • Fatigue • Loss of sleep • Nausea • Chills • Night pain • Anxiety • Stress • Seizures • Difficulty concentrating • Difficulty walking • Weakness (abnormal)	• Tingling in arms • Tingling in legs • Dizziness • Difficulty swallowing • Blurred vision • Numbness • Loss of balance • Slurred speech • Memory loss • Loss of consciousness • Tremors/ shaking • Convulsions • Loss of bowel control • Loss of bladder control	• Painful urination • Difficulty initiating urination • Blood in urine • Kidney stones • Urinary Tract Infection **Gastrointestinal** • Loss of appetite • Painful bowel movement • Diarrhea • Constipation • Abdominal pain • Peptic ulcer • Celiac Disease • Irritable Bowel Syndrome • Indigestion • Vomiting • Excessive thirst • Excessive hunger • Water retention • Colitis	• Eczema • Unusual mole/ lump • Rashes/itching • Hives • Boils • Bruise easily • Jaundice or change in skin colour **Cardiovascular** • High blood pressure • Low blood pressure • Chest pain/Angina • Varicose veins • Swelling of feet/ankles • Chest palpitations • Rapid heartbeat • Deep vein thrombosis	• Difficulty breathing • Shortness of breath • Frequent cough • Coughing up blood • Coughing up mucous • Asthma/wheezing • Pneumonia • Bronchitis • COPD or Emphysema **Eyes/Ears/ Nose/Throat** • Sensitive to light • Sensitive to sound • Loss of vision • Loss of hearing • Earache • Ringing in ears • Loss of taste/smell • Frequent colds • Sinus issues • Thyroid problems • Clicking jaw • Dental problems • Sore throat	• Prostate Problem • Sexual dysfunction • HIV • Lump in breast • Painful menses • Irregular period • Cramping/ Backache • Menopause • Breast pain • Complex pregnancy

Family History: Have any of your immediate family members been diagnosed with any of the following? Please check the appropriate boxes.

☐ Cancer
☐ Heart Disease
☐ Stroke
☐ Diabetes
☐ Lupus
☐ Arthritis (Rheumatoid arthritis, Ankylosing Spondylitis, Psoriatic arthritis, Juvenile Idiopathic arthritis)
☐ Connective Tissue Disorder (EDS, Marfan, etc)
☐ Osteoporosis
☐ None

Please circle all the areas on the chart below where you are experiencing the pain:



Lifestyle

Please rate the following (1 being none/poor, 5 being high/great)

Stress level:	1	2	3	4	5
Physical activity:	1	2	3	4	5
Diet:	1	2	3	4	5
Sleep & Energy levels:	1	2	3	4	5

Do you consume the following; if so please indicate how much per day
Coffee: _____
Tobacco: _____
Alcohol: _____
Soft drinks: _____
Black tea: _____
Cannabis: _____

Do you have cold hands or feet? ☐ Yes ☐ No

Outlook on life: do you feel positive about life? _____

Is there anything additional you would like your practitioner to know? _____
_____
_____
_____

Patient Signature: _____
Date: _____

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Cancellation Policy

We require 24 hours notice for all cancellations. Any late cancellation (within 24 hours of appointment time) or no showed visits will incur a fee. The fees are as follows:

50% of the visit fee for the first missed or late cancelled appointment.
100% of the visit fee for subsequent missed or late cancelled appointments.

We will require a credit card on file after the first missed or late cancelled appointment that will be charged for any future late cancellations or missed appointments.

You will not be charged for late cancellations due to inclement weather.

I understand that 24 hours' notice is required for appointment cancellation; otherwise, I will be responsible for the cancellation fee.

_____	_____
Patient Name: (Please Print)	Name of guardian if patient is a child
_____	_____
Signature of Patient (or Guardian)	Today's Date

Optional Consent (please initial box)

☐ I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

Signature: _____

Claims and Consent

I hereby assign benefits payable fo the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the even my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept the Assignment, that any benefit payment made in accordance with this assignment will discharge the insurer/plan administrator of its obligations with respect to that payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am the spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Signature: _____