Dr. Anita Komonski, B.Sc., ND

Naturopathic Physician

202-901 Island Highway
Campbell River, BC V9W 2C2
250.504.0090 www.drkomonski.com

New Patient Acupuncture Intake Form

Patient Name: _____ Date: _____
PLEASE PRINT (Last) (First) (Middle)

Successful comprehensive health care is only possible when the physician has a complete understanding of the patient's physical, mental and emotional condition and history. Please answer each question completely, marking anything you have a question about. Your time, thoughtfulness and honesty is appreciated and will greatly aid me in evaluating your health needs. All answers are completely confidential.

Address: _____ City: _____ Province: ___ Postal Code: _____
Phone: (home)_____ (work)_____ (cell) _____
Email: _____ Please circle preferred method of contact
Can messages be left confidentially? Y N
Emergency Contact: _____
Name Phone number Relationship

MSP (Care Card) #: _____ Date of Birth: _____
Age: _____ Gender: _____ Occupation: _____

How did you hear about Dr. Komonski? _____

Name of primary health care physician: _____

What is your main reason for coming in today?

_____
_____
_____

What kind of treatment have you received? _____

Do you have any known contagious diseases at this time? N Y: _____
Do you have any known life-threatening allergies? N Y: _____

Current medication (prescription & over the counter), nutritional supplements, natural remedies (please list dosage)

_____ _____
_____ _____
_____ _____

Do you have a pacemaker or any metal implants (ex. screws)?_____

Review of Systems – Please check all current or recurring problems.

QI

☐ Easily fatigued	☐ Shortness of breath	☐ Sweating with little/no exertion	
☐ Dizzy/lightheaded	☐ Hard to project voice	☐ Poor appetite	☐ Loose stools
☐ Bloating/fullness	☐ Stuck feeling in throat	☐ Repeated throat clearing	☐ Frequent sighing
☐ Depression	☐ Irritability	☐ PMS	
☐ Fullness in chest	☐ Heaviness in head/body	☐ Sensation of bearing down	☐ Organ prolapse/hernia

YIN/YANG

☐ Irritability	☐ Dry mouth/throat	☐ Insomnia	☐ Heat in hands/feet/chest
☐ Flushed cheeks	☐ Night sweats	☐ Hot flashes	☐ Feverish in afternoon ☐ Anxiety
☐ Constipation	☐ Dark, scanty urine	☐ Prefer cold drinks	☐ Prefer cool environment
☐ Thirst with no desire to drink			

☐ Chills	☐ Cold hands	☐ Cold feet	☐ Inability to get warm
☐ Profuse clear urine	☐ Sweat easily	☐ Loose stools	☐ Desire to sleep a lot
☐ Retain water	☐ Prefer warm drinks	☐ Enjoy spicy food	☐ Prefer warm environment

BLOOD

☐ Dizziness	☐ Palpitations	☐ Insomnia	☐ Dry skin/hair	☐ Fatigue	☐ Anemia
☐ Pale face/nails	☐ Scanty periods	☐ Blurry vision	☐ Poor memory	☐ Short menstrual cycles	

☐ Localized sharp pain	☐ Cysts/lumps/masses	☐ Blood clots	☐ Painful menses

TRADITIONAL CHINESE MEDICINE ORGAN FUNCTION

KIDNEY/URINARY BLADDER

☐ Low back pain	☐ Sore knees	☐ Weak knees	☐ Sweaty hands/feet	☐ Poor memory
☐ Easily startled	☐ Wake to urinate	☐ Bladder infections	☐ Frequent cavities	☐ Incontinence
☐ Hair loss	☐ Asthma	☐ Cold limbs	☐ Weakness in legs	☐ Low libido
☐ Weak bones (Osteoporosis/osteopenia/previous fractures)			☐ Ringing in ears (low-pitched)	☐ Hearing loss

SPLEEN

☐ Easy bruising	☐ Over-thinking	☐ Abrupt weight loss/gain	☐ Worry	☐ Pensive
☐ Fatigue after eating	☐ Hemorrhoids	☐ Abdominal gas/bloating	☐ Gurgling noises in stomach	
☐ Heaviness in body	☐ Itchy/burning anus	☐ Weakness in arms & legs	☐ Loose stools	☐ Excess phlegm

STOMACH

☐ Large appetite	☐ Bad breath	☐ Heartburn	☐ Bleeding/swollen/painful gums
☐ Canker sores	☐ Belching	☐ Hiccups	☐ Burning sensation after eating
☐ Vomiting	☐ Stomach pain	☐ Ulcer (previously diagnosed)	

LUNG

☐ Nose bleeds	☐ Sinus congestion	☐ Stiff neck/shoulders	☐ Sneezing	☐ Nasal discharge
☐ Dry mouth/throat	☐ Difficulty breathing	☐ Headache	☐ Allergies _____	
☐ Frequent colds	☐ Hoarseness	☐ Cough: Dry or wet	☐ Sputum – colour_____	

HEART

☐ Palpitation	☐ Restlessness	☐ Anxiety	☐ Confusion	☐ Frequent dreams
☐ Waking unrefreshed	☐ Chest pain	☐ Fidgeting	☐ Tongue/mouth ulcers	☐ Bitter taste in mouth

LIVER/GALLBLADDER

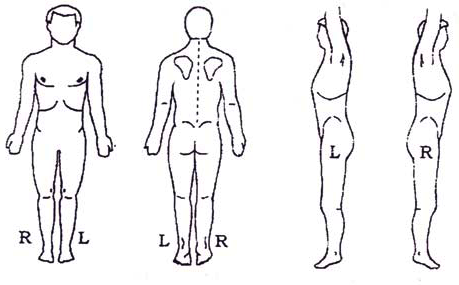
☐ Sighing	☐ Nausea/vomiting	☐ Mood swings	☐ Upper abdominal pain/distention
☐ Diarrhea/constipation	☐ Breast tenderness	☐ Genital pain	☐ Swelling/itching genitals
☐ Bitter taste in mouth	☐ Floaters	☐ Blurred vision	☐ Ringing in ears (high-pitched)
☐ Shoulder tension	☐ Tremors/tics	☐ Anger easily	☐ Numbness in extremities
☐ Dry hair/skin	☐ Skin rashes	☐ Gallstones	☐ Muscle twitches/spasms

☐ Irritability ☐ Easily stressed ☐ Easily frustrated ☐ Indecisiveness

PAIN/DISCOMFORT

☐ Joint pain/stiffness ☐ Muscle weakness ☐ Numbness ☐ Muscle cramps ☐ Sciatica

Type of pain: ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Dull ☐ Tingling ☐ Shooting ☐ Spasm ☐ Aching
☐ Burning ☐ Sore ☐ Tender ☐ Heavy ☐ Twisting ☐ Other: _____
Pain is better with: ☐ Cold ☐ Heat ☐ Rest ☐ Exercise ☐ Pressure ☐ No contact ☐ In the morning ☐ Later in day
Mark areas of pain:



GENERAL

☐ Cravings: sweet/salty/fat ☐ Slow wound healing ☐ Seizures ☐ Poor concentration
Taste in mouth: ☐ Tasteless ☐ Bitter ☐ Sweet ☐ Sour ☐ Salty ☐ Dry ☐ Damp
Thirst: ☐ No thirst ☐ Thirst with desire to drink in gulps ☐ Thirst with desire to sip ☐ Thirst with no desire to drink
How much water do you drink?_____ Time of day you get thirsty? _____
☐ Awake feeling rested ☐ Sleep well How many hours of sleep per night? _____
☐ Do you cook your own meals? How often do you eat out? _____
☐ Do you enjoy your work? Any occupational hazards? _____

MALE

☐ Testicular pain ☐ Prostate problems ☐ Erectile dysfunction ☐ Sexually transmitted infection
☐ Premature ejaculation ☐ Discharge/sores

FEMALE

Age of first menses_____ ☐ Is there a possibility that you could be pregnant? ☐ Irregular menses
Length of cycle (blood flow to next blood flow)_____ Duration of menses (days of bleeding)_____
☐ Heavy flow ☐ Light flow ☐ Spotting between periods ☐ Clots ☐ Blood colour (Bright/deep red, purple, brown)
☐ Vaginal discharge ☐ Sexually transmitted infection ☐ Breast pain/tenderness ☐ Breast lumps
☐ Difficulty conceiving Number of pregnancies___ Number of live births___ Number of miscarriages___

CONTEXT OF CARE

Why did you choose to come to *this* clinic?

What expectations do you have of *today's* visit to our clinic?

What *long-term* expectations do you have?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle habits? Rate from 0-10, where 10 is 100% committed.

0 1 2 3 4 5 6 7 8 9 10

What potential *obstacles* do you foresee in addressing the lifestyle factors that may be undermining your health and adhering to the treatment guidelines we will be sharing with you?

Thank you for your time and effort. We look forward to providing you with the best possible care.

Declaration and Informed Consent to Acupuncture and TCM Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic physician board-certified in acupuncture, we will conduct a thorough case history, and use diagnostic tools such as pulse reading, palpation, and observation of the tongue. I use therapies such as Acupuncture/Traditional Chinese Medicine, cupping, Gua Sha, Tui Na, nutrition counseling, and lifestyle counseling to assist the body's innate healing capacity and to improve overall health and wellbeing.

Statement of Acknowledgement

Printed name_____

As a patient of Dr. Komonski, I have read the information and understand that the form of medical care is based on **Acupuncture and TCM** principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information provided is complete, accurate and inclusive of all health concerns including the risk of pregnancy and all medications, including over the counter drugs and supplements. **Slight** health risks of some Acupuncture and TCM treatments include, but not limited to: temporary aggravation of pre-existing symptoms, fainting, bruising or injury from acupuncture, bruising from cupping.

I also recognize the following:

- Information revealed during the course of a visit is **strictly confidential**. Exceptions to this confidentiality include disclosure regarding intention to seriously harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor.
- A record will be kept of my visits. This record and the information provided **will not be disclosed** to others without my consent, or unless the law compels or authorizes Dr. Komonski to do so. I understand that I may look at my medical records at any time and can request a copy of them.
- I will be given the opportunity to discuss and ask questions regarding any treatment plan. I have the ability to **accept or reject this care** of my own free will and choice.
- Any treatment or advice provided to me as a patient of Dr. Komonski is **not mutually exclusive** from any treatment I may now be receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care from a medical doctor or other licensed healthcare provider. I will inform Dr. Komonski of other treatments that I may be receiving concurrently, or plan to receive while following the treatment plan. I understand that results are not guaranteed.
- I am responsible for **full payment** at the time of each visit for services. In the case of premium assistance, I will pay all fees up front and request a reimbursement.
- I am aware that a **minimum of 24 hours notice** must be given for all rescheduled or cancelled appointments. A missed appointment fee will be charged for missed sessions without such notification.
- I understand that Dr. Komonski reserves the right to determine which cases fall outside their scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive Acupuncture and TCM treatment from Dr. Komonski. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____