Where You Truly Matter

Lifestyles

EST 2005

Wellness · Coaching · TCM · Yoga · Retreats · Workshops · Spa

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CLIENT INTAKE FORM

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____City: _____Postal Code: _____

Telephone: _____Email: _____Referred by: _____

Emergency Contact Name: _____Relationship: _____Tele: _____

Employer: _____ Occupation: _____

Email/ E-newsletter: Periodically I send out an e-newsletter updating patients on clinic news and events providing helpful holistic health care information. Your email address will not be shared. Would you like to receive our e-newsletter to the email address provided? Yes No

Welcome to Lifestyles. We emphasize the team approach to wellness, prevention and treatment of disease. Our purpose is to help you achieve and maintain your health-related goals and optimal health. We work together with you, that means you are invited to participate as actively as possible in the work we do together. We provide some services which are commonly reimbursed by typical insurance companies. Insurers vary in their rules, regarding acupuncture, nutrition, massage therapy and other modalities. Because of the changing nature of this system, private payment is necessary for our services at the time of your visit. We will provide all necessary documentation to you in order for you to submit a claim for reimbursement to your insurer.

Please provide at least 48 hours to cancel or reschedule. Please arrive on time. Please turn your phone to vibrate. Please remove outdoor footwear. It is recommended to bring water and a snack to your treatments. Please refrain from moving while your needles are inserted. Please wear comfortable loose clothing.

We look forward to becoming health partners with you.

Please initial the box to provide your consent:

☐ I authorize Kelly Linstead or her associates to release information to my insurance company pertaining to my health care in order for them to process a claim which is being submitted for reimbursement.

☐ I understand that my consent to treatment is voluntary, and I have the right to withdraw my consent at any time.

☐ Kelly Linstead does not bill insurance companies directly. I am responsible for the full payment of my booked services.

☐ Shall I provide 24 hours or less notice to cancel or reschedule, I agree to pay immediately 60% of the service total. Shall I not show for my appointment or I arrive 15 minutes + late, I understand I have missed my appointment and I therefore agree to pay immediately 100% of the service total.

☐ I understand if I am late for my appointment, it will shorten my time with the practitioner, my scheduled service will be shortened to ensure time is not taken from another patient.

☐ I understand items purchased are non-refundable, whether or not they have been opened.

Acupuncture, Traditional Chinese Medicine (TCM) modalities such as moxa, Gua Sha, cupping, herbal medicine, aromatherapy, reiki, massage, nutrition, yoga, breathwork, meditation and exercise are safe and effective for the prevention and treatment of a wide range of health problems and for the promotion of general well being. Although TCM is helpful for many health conditions, it is not intended to replace any tests or treatments recommended by your physicians. It is advised that you inform your physician and other practitioners of your choice of various treatment modalities so that a team approach may be employing to treat you. Please also keep us up to date of your test results, changes to supplements or prescriptions, medical diagnoses and surgeries.
Please note that treatment can cause bruising, especially with cupping. Common also is post needling sensation, itching or redness. Fainting or abdominal upset may occur due to nervousness, hunger, dehydration or extreme fatigue. It is recommended to bring water and a snack to your treatments. Please refrain from moving or shifting clothing while your needles are inserted to avoid moving muscles and needles. Please wear comfortable loose clothing. If you have any concerns, please do not hesitate to ask.

Client Statement:
I _____ (undersigned patient) herby request and consent to receive treatment from Kelly Linstead for Traditional Chinese Medical treatments including acupuncture, cupping, moxa, Gua Sha, heat lamp, herbal medicine, Massage, herbal, essential oils, Reiki, nutritional and lifestyle coaching, stretches, yoga, strengthening exercise, breathwork and other related treatments and lifestyle coaching from Kelly Linstead. I acknowledge these treatment modalities and all its ramifications have been fully explained to me. I acknowledge that I have informed my practitioner about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.
As with all forms of therapy, I understand that Traditional Chinese Medicine & Acupuncture also has its limitations and thus I acknowledge that my practitioner cannot guarantee the results of the proposed treatment. Nor do I expect my practitioner to be able to anticipate and explain all risks and complications prior to treatment. I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Traditional Chinese Medicine & Acupuncture include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to herbs or oils, interactions with prescription medications, and pain, bruising, fainting or injury from Traditional Chinese Medicine, acupuncture, moxa, Gua Sha, cupping or massage.
I absolve Kelly Linstead as well as her clinic if I experience any unexpected effects resulting from the treatment or entering the premises. I further agree to not commence lawsuit of any kind against Kelly Linstead nor her clinic. I acknowledge that I have asked any questions I may have and received answers I understand.
With this knowledge, I voluntarily consent to Traditional Chinese Medicine & Acupuncture treatment, lifestyle coaching and other modalities as discussed and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.
Patient name (Please print): _____
Signature of Patient or Guardian if under age 18: _____ Date: _____

Client name _____ Signature _____

Parent or guardian name, if under age 18. _____Date _____

Client Medical History:

Please circle any that apply to you

Diabetes, Hypoglycemia, High Blood Pressure, Low Blood Pressure, Anaemia, Hypo or Hyper Thyroid, Goiter, Nodules, Cancer, Heart Disease, Intestinal disease, Hiatal Hernia, Depression, Alzheimer's, Ulcers, High cholesterol, Seizures, Prostate problems, Arthritis, Psoriasis, Infertility, Liver disease, Stroke, Heart attack, Addictions, Severe burns, Neurological condition, Psychological illness, Contagious disease, Appendicitis, Malaria, Chicken pox, Alcoholism, Drug use, Osteoporosis, Venereal infection, Cold sores, Whooping cough, Epilepsy, Multiple sclerosis, Parkinsons, Heart disease, Tuberculosis, Pneumonia, Measles, Goiter, Eczema, Mumps, Influenza, Gout, Polio, Pleurisy, Pneumatic fever, Rubella, HIV/AIDS

Please list details and years of any relevant medical history including past and present, any hospitalizations, surgeries, injuries, medical conditions, infectious disease, allergies, drug reactions, long-term treatments etc.

_____

_____

_____

_____

_____

Family medical conditions or diseases that may be relevant to your health.

_____

_____

_____

Please list any medication you are currently taking (prescription or over the counter):

Medication _____ Reason _____Year_____

Medication _____ Reason _____Year_____

Medication _____ Reason _____Year_____

Medication _____ Reason _____Year_____

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking:

Supplement _____Dose_____ Reason _____

Supplement _____Dose_____ Reason _____

Supplement _____Dose_____ Reason _____

Supplement _____Dose_____ Reason _____

Health care providers and other treatments –medical or holistic

Name_____Telephone # _____ Type of care _____

Name_____Telephone # _____ Type of care _____

Name_____Telephone # _____ Type of care _____

Please list any allergies: _____

Are you pregnant ☐ Yes Due Date: _____ ☐ No Do you Smoke☐ No ☐ Yes Amount _____

Please take the time to complete the form honestly and in complete detail

What would you most like to achieve through your treatment?

_____

_____

Condition: began, factors that help or worsen your condition, tests performed and results, treatments tried or currently using, medications tried or currently using:

_____
_____
_____

Please list types of physical activity and frequency:

_____

_____

Diet & Digestion:

How is your appetite? _____How many meals do you eat per day? _____

What times do you usually eat? _____

Do you crave flavors: Sweet Salty Sour Bitter Spicy Do you avoid any foods? If so, please list and why:

_____

Were you frequently given antibiotics as a child? Y N Approximate ages: _____

Do you have thirst? Y N Preference for **hot** or **cold** drinks (circle)

How many cups daily: Coffee ____ Tea ____ Soft drink____ Alcohol____ Water____ Juice____ Milk_____ Other: ___

What would you eat in a typical day?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are you a: ☐Meat eater ☐Vegetarian ☐Vegan Since_____ Reason _____

How often do you consume meat: _____ Source/type of meat_____

How often do you consume dairy: _____ Source/type of dairy_____

Please CIRCLE any symptoms.

Urine

Back pain with urination or holding urine	Delayed, interrupted, weak stream	Leak	Mid day
Bladder infections	Difficult	Smell	_____
Kidney stones	Frequent urine	Night urine, how many times	(clear, light yellow, dark yellow, bright yellow)
Kidney inflection	Urgent urine	_____	
Burning	Small amount	Colour: am	
Blood	Profuse amount	_____	

How many bowel movements each day? _____ What times? _____

How are your bowel movements?

Diarrhoea/constipation/alt	Smelly	Burn	Hard to digest fats or raw
Urgent	Bulky and long	Itchy	food
Loose	Bulky and small	Mucous	Haemorrhoids
Narrow	Pellets	Painful to pass	Candida
Mushy	Dry clumps	Blood in stool	Parasites
Wet	Straining	Undigested food	Color of stool:
Sticky	Not empty		_____
	Vomit	Cramp	
Bad Breath		Spasm	Liver issues
Dry mouth	Heartburn	increase/decrease	Hepatitis
Excess thirst	Belching	appetite	Enlarged liver
No thirst	Bloat/full	Tired before/after meal	Enlarged spleen
Hungry	Gas	Miss meal: confused,	Gall bladder issues
Crave ice	Distended	irritable, dizzy, poor focus,	Ulcers
Nausea	Burn in throat or abdomen	shaky, clammy	

Chest, Breathing

Palpitation	Irregular heart beat		
Pounding	shortness of breath	Sinus Problems	Asthma/Wheezing
Sweating	Vertigo/Dizziness	Chest Pain	Phlegm (please describe)
Heaviness	Difficulty Breathing	Chest Tightness	_____

Breast:

swell,	lump	tender	produce milk w/o nursing

Temperature

Chills	Fever	Spontaneous sweat	Rare to sweat	Strong body odour	Pour circulation

Head:

poor memory	dizzy	poor balance/coordination	poor concentration/ confused	forgetful	
faint	fuzzy, foggy			lose thought	vertigo

Headaches/migraines Frequency _____

Location

all-over	front	temple	eyes	nape of neck	top of head

Type

dull	squeezing	sensitive to rain	noise	worse when tired	waking
sharp pain	expanding	light	food	hungry	evening
stabbing pain	Neck tension	smell	hormonal headaches	stressed	getting up to stand
pressure					

Hair:

loss	dandruff/ dry scalp	oily	brittle	thin	early grey	excess growth	less growth

Skin:

fungal infections	color –yellow, red, pale	poor wound healing	sensitive to sun
rash	sores	white patches	bumps on back of arms
hives	acne	bruise/bleed easily	poor tone/elasticity
increase pigment	boils	dry/itchy	

Lu & Nose

allergies season_____	frequent colds/flu -# of times past year_____	breath –deep/shallow
cough –dry or mucous	nosebleed	Shortness of breath
asthma	dry nose	ill with damp conditions
wheezing	deviated septum	sinus congestion
Chronic cough	snore	Sinus infections -# of times past year_____
	nasal drip	

Frequently phlegm –color _____, noticed when_____

Ears

wax –Hard or Moist	infection -# of times past year_____	Started _____	High pitch
discharge	hearing loss –Right or Left	ringing/buzzing –Right or Left	Low pitch
itchy			Ache when_____

Eye

Infection	Crossed eyes	dry/burn	watery	Sensitive
Vision problem	Lazy eye	strain/pain	puffy	color of the whites of the eye: _____
Glaucoma	spots/floaters	heavy	blurry	

Mouth

Dry	hard to chew/open	smell/taste: foul, sweet, bitter, burnt	mouth/tongue sores (cankers)

Tongue

Twitch	Swollen	Tender

Throat

hard to swallow	swollen	sore	dry	tonsilitis

Teeth

Grind	**Gums**	Bleeding	receding
tooth decay	Inflamed		

Lips

Dry	Sores	Crack	Swollen	color of lips: _____

Nails

Blue	brittle/thin	peel	pitted	white spots

Body

recent weight gain/loss	feel heavy	Varicose veins

Lymph

water retention -Location:	_____	swell throat/armpits/groin

Bones, joints, muscles

TMJ	Thigh pain	poor grip strength	numb
Neck pain	Knee pain	muscle loss	restless legs, cramp, twitch
Trap pain	Ankle pain	spinal curvature	aches/stiff/pain
Shoulder pain	Plantar pain	poor posture	decreased range
Back pain	Feet pain	decrease height	better with movement/exercise
Hip pain	Toe pain	swelling	worse with movement/exercise
Elbow pain	Finger pain	swollen joints	
Wrist pain	Crack	calcium deposits	
Pelvic pain	poor posture	poor flexibility	
Groin pain	weak	shaky	

List location of symptoms: _____

Emotions

Depressed	Shy	Restless	Overworked	Perfectionist
Suicidal	Hyper	Irritable	feel stuck	
Anxiety	Aggressive	Frightened	hard to carry out	
Nervous	Obsessive	Stress	plans	

How do you handle your emotions? _____

Do you feel fulfilled in your current career? _____

Are you in a positive work environment –boss, co-workers, clients? _____

How many hours do you work each day _____ each week? _____ Shift work? _____

Steady hours? _____Financial security_____ Time to commute to work? _____ High traffic? _____

Do you have support from friends/family?_____

Energy

Exhausted	Sluggish	Decreased with stress/exercise/	Decreased with food or caffeine
Sleepy	Excess		

Sleep

hard to fall asleep/stay asleep

hard to fall back to sleep

insomnia

wake tired

sleep apnoea

vivid dreams –types of dreams

_____

How many hours of sleep do you get each night?

_____

# of times you wake_____

Reasons you wake:

light sleeper, hot, sweat, thinking, urinate, restless body, aches

Libido

Increase

decrease

painful

Male

Infertility diagnoses _____ date _____

Treatments/medication_____

painful testes

ejaculation

swelling groin

erectile dysfunction

dysfunction impotence

Female Only

Age menses began: _____Date of last menstrual period began _____ Today is day _____ in my cycle.

Are your menstrual cycles regular? Yes No Cycle length (1st day of menses to 1st day of next menses) _____
Have your cycles changed since they began? Yes No How_____
Perimenopausal year_____
Menopausal year _____ Last Pap test _____ Results _____
Mammogram: date _____ Results? _____
Hysterectomy Date _____ Ovaries removed
How many days do you normally have your menses (flow) _____

Menses:

Loose mud stool
Watery stool
Stringy stool
No bowel movement
Dry compact stool
Small pellet stool
Spotting
Dark red
Breast tenderness
Upset stomach
Nausea
Vomiting

Pink
Bright red
Black
Brown
Sticky
Mucus
Bright red
Starts/stops
Emotional: anger, sad, depressed, foggy, fearful, anxious
Restless

Heavy
Gushing
Moderate flow
Light, scanty flow
Large clots
Moderate clots
Small clots
Lingers
Insomnia
Sexual dreams
Light headed
Ringing in the ears

Extremely painful
Mild cramps
No cramps
Medication for menstrual cramps
Miss work due to cramps

Floaters in eyes
Shortness of breath

Ovulation: Ovulate on Day _____
Do you ovulate on your own: Yes No Painful Breast tenderness Increased libido

Cervical mucous:

good amount
excess amount

small amount
none

raw egg white/stretchy/clear mucous
odour

2 weeks before menses:

spotting
confused/forgetful
headache
Loose mud stool
Watery stool
Stringy stool

No bowel movement
Dry compact stool
Small pellet stool
palpitations
tired
exhausted

anxiety
nervous
fearful
irritable/anger/resentful
depressed/hopeless

nausea
vomiting
weight gain
water retention/bloat
frequent urination
low back pain

breast tenderness
insomnia
increase sweat
breakouts
abdominal cramping

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Any problems during pregnancy, birthing or postpartum? _____

Have you ever had

cervical biopsy
Pelvic operation
cauterization
conization
venereal disease

yeast infection:
frequency
_____
Medication?
_____

chlamydial infection
chronic vaginal discharge
genitalia sores
pelvic inflammatory disease

uterine fibroids
polyps
endometriosis
pelvic adhesions
pelvic abnormalities

Any past gynaecological medications:
Medication _____ Condition _____Year_____
Medication _____ Condition _____ Year_____

Infertility diagnosis
How long have you been trying to conceive? _____Your partner supportive to conceive? ☐Yes ☐No
Any fertility treatments: Diagnosis_____
Treatment_____
Medications _____
Surgeries _____

Ovulation medication dates _____
Fallopian tubes evaluated medically, Date: _____Results _____
Tubal operations? Date: _____
Ever taken oral contraceptives: Dates_____
IUD: Dates_____
Depo-Provera: Dates_____
Libido
High
Low
Painful

Douche
Vaginal lubricants
Steroids
20% over your ideal body weight

20% below your ideal body weight
Excessive facial hair
Hair on nipples

Discharge from nipples
Excessively oily skin
Hair loss

Known toxin exposure while in uteral
Exposed to known environmental toxins or hormones

Thank you for taking the time to complete the form honestly and in complete detail. Please return to practitioner.

T: Shape: thin, swollen, teeth mark Colour: pale, red, purple Coating: white, yellow, dry, greasy, others Marks

P: L: Float, Deep, Slow, Rapid, Def, Excess, Slippery, Chop, Wiry **R**: Float, Deep, Slow, Rapid, Def, Excess, Slippery, Chop, Wiry

TCM Diagnosis: _____

Treatment (Acupuncture, Tuina, Moxa, Cupping, Gua Sha, Herbal, Nutritional, Stretch, Exercise, Lifestyle)

_____

_____

_____

_____

Supplement _____

Patient Name: _____ **Age:** _____ **Date:** _____