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	(clear, light yellow, dark yellow, bright yellow)
Kidney stones	Frequent urine	Night urine, how many times ____________________	
Kidney inflection	Urgent urine	Colour: am ____________________	
Burning	Small amount		
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 food
Urgent	Bulky and long	Itchy	
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 appetite	Hepatitis
Excess thirst	Belching		Enlarged liver
No thirst	Bloat/full	Tired before/after meal	Enlarged spleen
Hungry	Gas	Miss meal: confused, irritable, dizzy, poor focus, shaky, clammy	Gall bladder issues
Crave ice	Distended		Ulcers
Nausea	Burn in throat or abdomen		

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/coordi nation	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		food		evening
stabbing pain	Neck tension	light	hormonal headaches	hungry	getting up to stand
pressure		smell		stressed	

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___________________
cough –dry or mucous
asthma
wheezing
Chronic cough

frequent colds/flu -# of times past year________________
nosebleed
dry nose
deviated septum
snore
nasal drip

breath –deep/shallow
Shortness of breath
ill with damp conditions
sinus congestion
Sinus infections -# of times past year______________________

Frequently phlegm –color ___________________, noticed when____

Ears

wax –Hard or Moist
discharge
itchy

infection -# of times past year_________________
hearing loss –Right or Left

Started
____
ringing/buzzing –Right or Left

High pitch
Low pitch
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
tooth decay

Gums

Bleeding — receding
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 plans	
Nervous	Obsessive	Stress		

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	yeast infection:	chlamydial infection	
Pelvic operation	frequency	chronic vaginal	uterine fibroids
cauterization	_______________	discharge	polyps
conization	Medication?	genitalia sores	endometriosis
venereal disease	________________	pelvic inflammatory	pelvic adhesions
		disease	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:	IUD:	Depo-Provera:
Dates______________________	Dates______________________	Dates______________________

Libido

High	Low	Painful

Douche	20% below your ideal	Discharge from	Known toxin exposure
Vaginal lubricants	body weight	nipples	while in uteral
Steroids	Excessive facial hair	Excessively oily skin	Exposed to known
20% over your ideal	Hair on nipples	Hair loss	environmental toxins or
body weight			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)

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____

____

Supplement ____

Patient Name: ______________________________ **Age:** _________ **Date:** ____________________