Dr. Ladan Mohammadi, DTCM, R. TCMP, R.Ac, PhD.
412- 5050 Kingsway, Burnaby
www.metrotownacupuncture.com
Phone: 604-451-1737

Patient Intake Form

Patient Information			
Last name:		First Name:	Middle Name:
Birth Name/Other Previous Names:			Gender: M / F
Home Address:			Date of Birth: (DD/MM/YY)
City:	Province:	Postal Code:	Age:
Phone:		Mobile:	Occupation:
Fax:		Email:	

Family Contact Information		
First name:		Last name:
Relationship to Patient:	Phone Number:	Mobile Number:

Emergency Contact information (If different from above)		
First name:		Last Name:
Relationship to Patient	Phone Number:	Mobile Number:

Family Doctor Contact Information			
Family Doctor Name:			
Address:			How did you find out about us?
City:	Province:	Postal Code:	
Phone:	Fax:	Email:	

Reasons for Visit

1.

2.

3.

Past Medical History

☐ Mumps ☐ Herpes ☐ Hepatitis ☐ HIV+ ☐ Osteoporosis ☐ Tumor ☐ Measles
☐ Fracture ☐ Arthritis ☐ Gout ☐ Diabetes ☐ Tuberculosis ☐ High Cholesterol
☐ High Blood Pressure ☐ Muscle Sprain ☐ Stroke ☐ Cancer ☐ Low Blood Pressure (Hypotension)
☐ Others:

Special Considerations

☐ Pregnant ☐ Pacemaker ☐ Organ Transplant ☐ Implants ☐ Others:

Allergies/Drug Reactions

☐ Penicillin ☐ Peanut ☐ Dust ☐ Pollen ☐ Dairy ☐ Gluten ☐ Wheat ☐ Chocolate ☐ Caffeine
☐ Others:

METROTOWN NATUROPATHIC And Acupuncture

Dr. Ladan Mohammadi, DTCM, R. TCMP, R.Ac, PhD.
412- 5050 Kingsway, Burnaby
www.metrotownacupuncture.com
Phone: 604-451-1737

Informed Consent to Treatment

I voluntarily consent to acupuncture including other traditional treatment methods (see point 1 below) and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that acupuncture sessions include a complete intake of my health history and the use of sterile single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupressure, the electrical stimulation of needles, cupping, moxibustion, gua sha, herbal medicine, nutritional advice, and tuina. Before any of these procedures are performed, my acupuncturist will discuss treatment options and only proceed if my consent is given.
2. As with any procedure there are risks and symptoms of treatment which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved.
3. I will inform my acupuncturist if I: currently have or develop any major health issues, had any major surgeries or medical procedures, suffer from any type of major bleeding disorder, use a pacemaker, am pregnant, or think I could be pregnant.
4. I understand that I must let my acupuncturist know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of treatments and that acupuncture including other traditional treatment methods listed in point 1 above do not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases, my symptoms may temporarily worsen before they improve.
6. I am responsible for the full and prompt payment after services have been rendered.
7. I understand that I am expected to inform the clinic at least 24 hours' prior to my appointment if I need to cancel. Otherwise, I will be charged the full fee for my missed or late cancelled appointment.
8. I acknowledge that I have the right to ask any questions or refuse treatment. By signing this form, I give my informed consent to treatment by acupuncture and other traditional treatment methods listed in point 1 above.

_____ _____

Patient (or Legal Guardian) Signature Date

METROTOWN NATUROPATHIC And Acupuncture

Dr. Ladan Mohammadi, DTCM, R. TCMP, R.Ac, PhD.
412- 5050 Kingsway, Burnaby
www.metrotownacupuncture.com
Phone: 604-451-1737

Ongoing Health Conditions

- ☐ Headache
- ☐ Neck Pain
- ☐ Asthma
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Carpal Tunnel
- ☐ Fatigue
- ☐ Jaw Pain
- ☐ Depression
- ☐ Arthritis
- ☐ Menses Issues
- ☐ Plantar Fasciitis
- ☐ Bowel Problems
- ☐ Allergies
- ☐ Slipped Disc
- ☐ Stomach Pain
- ☐ Tingling in Legs and Arms
- ☐ Mid Back Pain
- ☐ Palpitations
- ☐ Hypertension
- ☐ Low Back Pain
- ☐ Poor Posture
- ☐ Knee or Hip Pain
- ☐ Pinched Nerves in Back or Neck
- ☐ Others:

Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization, Surgery, Injury	Date	Symptoms	Conditions Resolved?

Current medications/supplements: Please list ALL medications or supplements you take on a regular basis, and other

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner	Are You Taking Presently?

Family History: Has anyone in your family been diagnosed with any of the following conditions?

- ☐ Alcoholism
- ☐ Alzeimer's Disease
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Eczema
- ☐ Heart Disease
- ☐ High Blood Cholesterol
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Psoriasis
- ☐ Osteoarthritis
- ☐ Multiple Sclerosis
- ☐ Thyroid Disorder
- ☐ High Blood Pressure
- ☐ Others: