The Ontario Migraine Clinic

Patient Profile and Registration

Dedicated to Raising Awareness and Treatment of Migraine

Welcome to our clinic! The goal of The Ontario Migraine Clinic is to raise awareness and promote the use of complementary methods to treat migraines and other debilitating health problems. We successfully eliminate or reduce the frequency, severity and duration of these conditions while reducing the level of disability in the case of future attacks. Treatment consists of a unique method of acupuncture and the success has been nothing short of amazing.

Please take a moment to fill out all of the this form to the best of your knowledge. The information you provide is important to ensure we can give you the best possible care. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

PLEASE NOTE: Course of treatment will vary based on the individual. The average course of treatment is 30 to 100 treatments. Medication and not doing breathing exercises as well as individual response are the reasons for the variance. ***Breathing exercises must be performed a minimum of 3 times per day, as well as during the entire length of each treatment.***

✎ PERSONAL INFORMATION

FIRST NAME | LAST NAME | EMAIL ADDRESS

ADDRESS | CITY | PROV/STATE | POSTAL/ZIP CODE

PHONE NO.: RESIDENTIAL | BUSINESS | CELL | FAX

MARITAL STATUS | NO. OF CHILDREN | FAMILY MD | BIRTH DATE (M/D/Y) | SEX (M/F) | WEIGHT | HEIGHT

OCCUPATION | EMPLOYER | REFERRED BY (e.g. How did you find out about us?)

✎ PRIOR ACUPUNCTURE CARE

HAVE YOU HAD PREVIOUS ACUPUNCTURE CARE (YES/NO)? | IF YES, REASON(S) FOR DISCONTINUANCE OF TREATMENT

✎ REASON FOR VISIT

WHAT IS YOUR PRESENTING PROBLEM? (e.g. migraine, headache, etc.) | HOW LONG HAVE YOU SUFFERED? | HOW LONG HAS IT BEEN SINCE YOU FELT REALLY GOOD?

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?

IS THIS CONDITION GETTING WORSE? | IS IT CONSTANT OR DOES IT COME AND GO? | IS IT INTERFERING WITH: WORK/SLEEP/DAILY ROUTINE/OTHER (please list)

ANY OTHER PROBLEMS?

HAVE YOU HAD ANY OTHER PERSONAL INJURY OR ACCIDENT (Please list)? | LIST ANY SURGERY AND DATES

✎ FEES AND CANCELLATION

INITIAL VISIT (includes Consultation and Treatment)..... $150.00
TREATMENTS..... $85.00

APPLICABLE TAX NOT INCLUDED in these prices.
Payment is required at the time of treatment.
CANCELLATIONS: 24 HOURS NOTICE REQUIRED.

X

SIGNATURE | DATE

HEALTH HISTORY

Please indicate if you currently have, or ever had, any of the following conditions:

NOW	PAST	NO	CONDITION
❑	❑	❑	Allergies
❑	❑	❑	Poor Digestion
❑	❑	❑	Laxatives Use
❑	❑	❑	Stomach Gas
❑	❑	❑	Constipation (frequent)
❑	❑	❑	Ulcers
❑	❑	❑	Diarrhea
❑	❑	❑	Heartburn
❑	❑	❑	Brittle Fingernails
❑	❑	❑	Fatigue Easily
❑	❑	❑	Low Energy
❑	❑	❑	Chronically Tired
❑	❑	❑	Depressed After Work
❑	❑	❑	3 Hours TV Daily
❑	❑	❑	Frequent Colds
❑	❑	❑	Swallowing Problems
❑	❑	❑	Hands Get Cold
❑	❑	❑	Feet Get Cold
❑	❑	❑	Arthritis, Rheumatoid
❑	❑	❑	Diabetes
❑	❑	❑	Varicose Veins
❑	❑	❑	Cancer
❑	❑	❑	Irregular Menses
❑	❑	❑	Slow Healing Sores
❑	❑	❑	Arteriosclerosis
❑	❑	❑	Poor Circulation
❑	❑	❑	Hemorrhoids
❑	❑	❑	Hormone Problems
❑	❑	❑	Memory Loss
❑	❑	❑	Sex Desire Reduced
❑	❑	❑	Dizziness
❑	❑	❑	I.U.D.
❑	❑	❑	Vaginal Infections
❑	❑	❑	Heavy Metal Problems
❑	❑	❑	Essential Hypertension
❑	❑	❑	Hypoglycemia
❑	❑	❑	Overweight
❑	❑	❑	Moody Often
❑	❑	❑	Emotional Upsets
❑	❑	❑	Asthma
❑	❑	❑	Headaches. *Describe:*
❑	❑	❑	Chronic Pain. *Describe:*

NOW	PAST	NO	CONDITION
❑	❑	❑	Difficulty Sleeping
❑	❑	❑	Insomnia
❑	❑	❑	Bruxism
❑	❑	❑	Clenching
❑	❑	❑	Muscle Spasms
❑	❑	❑	Menstrual Cramps
❑	❑	❑	Menopausal Problems
❑	❑	❑	Shaking or Twitching
❑	❑	❑	Muscle Tremors
❑	❑	❑	Muscle Soreness
❑	❑	❑	Osteoarthritis
❑	❑	❑	Hand Tremors
❑	❑	❑	Leg Cramps
❑	❑	❑	TMJ Problems
❑	❑	❑	Periodontal Disease
❑	❑	❑	Nose Bleeds Often
❑	❑	❑	Dental Infections
❑	❑	❑	Dental Cavities
❑	❑	❑	Orthodontics Treatment
❑	❑	❑	Bleeding Gums
❑	❑	❑	Sore Mouth
❑	❑	❑	Metal Taste in Mouth
❑	❑	❑	Edentulous
❑	❑	❑	Painful Urination
❑	❑	❑	Frequent Urination
❑	❑	❑	Had Oral Surgery
❑	❑	❑	Cold Sores (Herpes)
❑	❑	❑	Ringing in Ears
❑	❑	❑	Hearing Loss
❑	❑	❑	Wear Glasses
❑	❑	❑	Gall Bladder
❑	❑	❑	Nervousness
❑	❑	❑	Lose Temper Easily
❑	❑	❑	Perfectionist
❑	❑	❑	Skin Rash
❑	❑	❑	Kidney Problems
❑	❑	❑	Blood Pressure
❑	❑	❑	Tobacco User
❑	❑	❑	Hyperactivity
❑	❑	❑	Cardiogram

NOW	PAST	NO	CONDITION
❑	❑	❑	Scoliosis
❑	❑	❑	Tonsillitis
❑	❑	❑	Heart Troubles
❑	❑	❑	Fast Pulse
❑	❑	❑	Chest Pains
❑	❑	❑	Heart Palpitations
❑	❑	❑	Scarlet Fever
❑	❑	❑	Lung Problems
❑	❑	❑	Pneumonia
❑	❑	❑	Chronic Cough
❑	❑	❑	Sinus Problems
❑	❑	❑	Drug Problems
❑	❑	❑	Hepatitis
❑	❑	❑	Mononucleosis
❑	❑	❑	Prostrate Problems
❑	❑	❑	Fainting Spells
❑	❑	❑	Polio
❑	❑	❑	Mental Health Problems
❑	❑	❑	Learning Disability
❑	❑	❑	Schizophrenia
❑	❑	❑	Psychological Care
❑	❑	❑	Numbness of Fingers
❑	❑	❑	Neck Injury or Operation
❑	❑	❑	Excessive Hair Loss
❑	❑	❑	Colitis
❑	❑	❑	Epilepsy
❑	❑	❑	Parkinson's Disease
❑	❑	❑	Cerebral Palsy
❑	❑	❑	Torticollis
❑	❑	❑	Multiple Sclerosis
❑	❑	❑	Drug Reaction
❑	❑	❑	Alcoholism
❑	❑	❑	Backaches
❑	❑	❑	Crave Salt
❑	❑	❑	Nervous Breakdown
❑	❑	❑	Swollen Hands
❑	❑	❑	Swollen Ankles
❑	❑	❑	HIV / AIDS

OTHER HISTORY NOT PREVIOUSLY MENTIONED

MEDICATION HISTORY

Are you currently, or have you ever, regularly taken any of the following medications:

NOW	PAST	NO	MEDICATION
❑	❑	❑	Barbiturates
❑	❑	❑	Thyroid
❑	❑	❑	Insulin
❑	❑	❑	Blood Pressure
❑	❑	❑	Heart
❑	❑	❑	Muscle Relaxants
❑	❑	❑	Nerve
❑	❑	❑	Pain
❑	❑	❑	Penicillin
❑	❑	❑	Tetracycline
❑	❑	❑	Stomach
❑	❑	❑	Cortisone
❑	❑	❑	Aspirin
❑	❑	❑	Laxatives

SPECIFY ANY OTHER MEDICATIONS

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE SPECIFY

FAMILY HISTORY

Have your mother or father, or their parents, had any of the following disorders:

YES	NO	DISORDER
❑	❑	Cancer
❑	❑	Diabetes
❑	❑	Arthritis
❑	❑	Allergies
❑	❑	Obesity
❑	❑	Hemorrhoids
❑	❑	Stroke
❑	❑	Alcoholism
❑	❑	Dental Problems
❑	❑	High Blood Pressure
❑	❑	Mental Health Problems
❑	❑	Heart Troubles
❑	❑	Arteriosclerosis
❑	❑	Kidney Disorders

EXERCISE

PLEASE DESCRIBE ANY REGULAR EXERCISE YOU DO

NUTRITIONAL HISTORY

Do you usually eat during the following time of day:

YES	NO	TIME OF DAY
❑	❑	Breakfast
❑	❑	Lunch
❑	❑	Dinner
❑	❑	Between meals
❑	❑	Before Bed

How often do you have:

3X DAILY	DAILY	3X WEEK	3X MTH.	NEVER	
❑	❑	❑	❑	❑	Milk
❑	❑	❑	❑	❑	Dairy Products
❑	❑	❑	❑	❑	Coffee
❑	❑	❑	❑	❑	De-Cafe Coffee
❑	❑	❑	❑	❑	Refined Sugar
❑	❑	❑	❑	❑	White Bread
❑	❑	❑	❑	❑	Artificial Sugar
❑	❑	❑	❑	❑	Soft Drinks
❑	❑	❑	❑	❑	Pastries
❑	❑	❑	❑	❑	Alcohol
❑	❑	❑	❑	❑	Beer
❑	❑	❑	❑	❑	Wine
❑	❑	❑	❑	❑	Salt
❑	❑	❑	❑	❑	Fresh Vegetables
❑	❑	❑	❑	❑	Frozen Vegetables
❑	❑	❑	❑	❑	Canned Vegetables
❑	❑	❑	❑	❑	Salads
❑	❑	❑	❑	❑	Fresh Fruit
❑	❑	❑	❑	❑	Frozen Fruit
❑	❑	❑	❑	❑	Canned Fruits
❑	❑	❑	❑	❑	Red Meats
❑	❑	❑	❑	❑	Fish
❑	❑	❑	❑	❑	Seafood
❑	❑	❑	❑	❑	Poultry
❑	❑	❑	❑	❑	TV Dinners
❑	❑	❑	❑	❑	Italian Food
❑	❑	❑	❑	❑	Chinese Food
❑	❑	❑	❑	❑	Fast Food (e.g. McDonald's)

PLEASE LIST ANY VITAMINS OR MINERALS YOU REGULARLY TAKE. SPECIFY AMOUNT.

ALLERGIES

PLEASE LIST ANY KNOWN ALLERGIES

The Ontario Migraine Clinic

Privacy Policy: Patient Consent

For Collection, Use And Disclosure Of Personal Information

Privacy of your personal information is an important part of our office providing you with quality acupuncture care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Brendan Cleary Ph.D, D.Ac. acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Do not hesitate to discuss our policies with any member of our office staff. Please be assured that every staff person in our office is committed to ensuring you receive the best quality acupuncture care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how the office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to access your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to communicate with other treating health care providers
- to allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
- to allow use to efficiently follow-up for treatment, care and billing
- for teaching purposes on an anonymous basis
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the Patient Consent section of this *Privacy Policy: Patient Consent* form, you have agreed that you have given your informed consent to the collection use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Our office will not under any conditions supply your insurer with your confidential medical history unless we seek your approval first. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information at any time.

✎ PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know your office has a Privacy Code, and I can ask to see the Code at any time.

I agree Brendan Cleary Ph.D. D.Ac. may collect, use and disclose personal information about myself as set out above in the information about the office's privacy policies.

PRINT NAME	X SIGNATURE	DATE	X SIGNATURE OF WITNESS