Patient Intake Form **Today's Date**

Name:	**Birth date:**
Address:	**Postal Code:**
Home Phone:	**Work Phone**
Occupation:	**email:**
Emergency Contact – Name:	**Phone:**

How did you hear about this clinic/practitioner?

Have you had acupuncture before? Yes ☐ No ☐ Chinese Herbal Medicine Yes ☐ No ☐

Are you under the care of a physician now? Yes ☐ No ☐

Physicians Name **Physicians phone number**

Other concurrent therapies

Family Medical History – grandparents, parents, siblings, etc.

☐ **Allergies** ☐ **Asthma** ☐ **Alcoholism** ☐ **Cancer** ☐ **Diabetes** ☐ **Heart Disease**

☐ **High Blood Pressure** ☐ **Low Blood Pressure** ☐ **Seizures** ☐ **Stroke**

Your Medical History

☐ Aids/HIV	☐ Chronic Fatigue	☐ Herpes	☐ Pacemaker	☐ Thyroid Disorders
☐ Alcoholism	☐ Diabetes	☐ High Blood Pressure	☐ Pleurisy	☐ Tuberculosis
☐ Allergies	☐ Emphysema	☐ Low Blood Pressure	☐ Pneumonia	☐ Typhoid Fever
☐ Appendicitis	☐ Epilepsy	☐ High Cholesterol	☐ Polio	☐ Ulcers
☐ Asthma	☐ Goiter	☐ Measles	☐ Rheumatic Fever	☐ Venereal Disease
☐ Birth Trauma	☐ Gout	☐ Menopausal Difficulty	☐ Scarlet Fever	☐ Whooping Cough
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Seizures	☐ Fibromyalgia
☐ Chicken pox	☐ Hepatitis	☐ Mumps	☐ Stroke	

☐ Major trauma (mva, fall, etc – list)

☐ Surgeries (list)

Your Diet

☐ High Appetite	☐ coffee	☐ Sweet Food	☐ Artificial Sweetener	Water: # of glasses per day -
☐ Normal Appetite				
☐ Low Appitite	☐ Soft Drinks	☐ Salty Food		

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Vitamins/Supplements

Lifestyle

Regular Exercise

Type	Frequency

Pharmaceuticals taken in the last 2 months:

☐Stress ☐Occupational hazards ☐Alcohol ☐Tobacco ☐Marijuana ☐Drugs

General Symptoms

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands or feet	☐ Night Sweats	☐ Peculiar taste
☐ Prefer cold drinks	☐ Dream-disturbed sleep	☐ Poor circulation	☐ Sweat Easily	(describe)
☐ Prefer hot drinks	☐ Fatigue	☐ Shortness of Breath	☐Muscle cramps	
☐ recent weight gain/loss	☐ Lack of strength	☐ Fever	☐ dizziness	

☐ Eye Strain	☐ Night blindness	☐ Gum problems	☐ Swollen glands	☐ Headaches
☐ Eye Pain	☐ Glaucoma	☐ Sores on lips or mouth	☐ Lump in throat	☐ Migraines
☐ Red Eyes	☐ Cataracts	☐ Dry mouth	☐ Enlarged thyroid	☐ Concussions
☐ Itchy Eyes	☐ Teeth problems	☐ Excessive Saliva	☐ Nose bleeds	Other head or neck
☐ Spots in Eyes	☐ Grinding teeth	☐ Sinus problems	☐ Ringing in ears	problems:
☐ Poor vision	☐ TMJ	☐ Excessive phlegm	☐Poor hearing	
☐ Blurred Vision	☐ Facial pain	☐ Recurrent sore throat	☐ Earaches	

☐ Difficulty breathing	☐ Tight chest	☐ Cough	Colour of Phlegm:	☐ Coughing blood
☐ Shortness of breath	☐ Asthma/wheezing	☐Wet or ☐Dry?		☐ Pneumonia
☐ blood clots	☐ fainting	☐ chest pain	☐ palpitations	☐ Irregular heartbeat

☐ Nausea	☐ Bad breath	☐ Mucous in stool	☐ Anal fissures	☐ colitus
☐ Vomiting	☐ Diarrhea	☐ Intestinal pain		
☐ Acid regurgitation	☐ Constipation	☐ Itchy anus	Bowel Movements:	
☐ Gas	☐ Laxative use	☐ Burning anus	Frequency:	
☐ Hiccough	☐ Black stool	☐ Rectal pain	Texture/ form	
☐ Bloating	☐ Bloody stool	☐ Hemorrhoid	Strong odor?	

☐ Neck/ shoulder pain	☐ Upper back pain	☐ Joint pain	☐ Limited movement	☐ Other
☐ Muscle pain	☐ Low back pain	☐ Rib pain	☐ Limited use	

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/ skin	☐ Other hair/ skin
☐ Hives	☐ Psoriasis	☐ Itching skin	☐ Fungal infections	problems:
☐ Ulcerations	☐ Acne	☐ Hair loss	☐ cycsts	

☐ Seizures	☐ Poor memory	☐ Irritability	☐ Seeing therapist	☐ Other:
☐ Numbness	☐ Depression	☐ Easily stressed	☐ Considered/attempted	
☐ Tics	☐ Anxiety	☐ Abuse survivor	suicide	

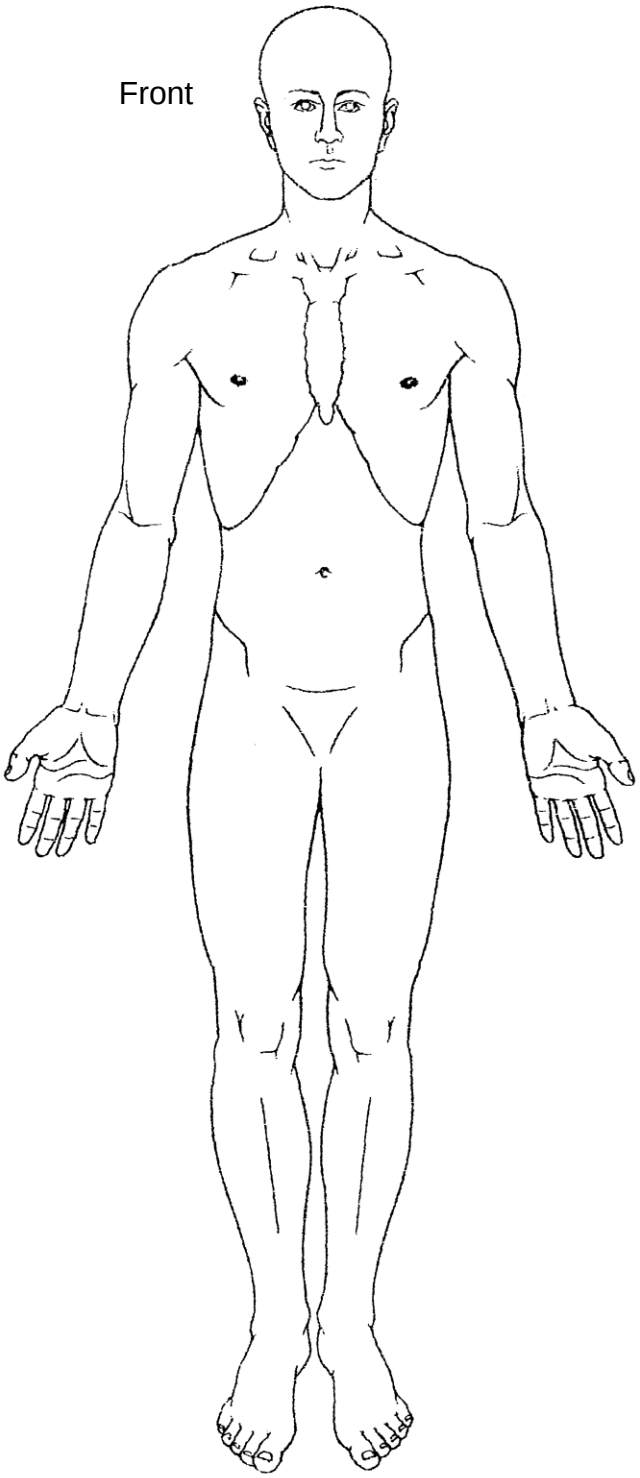
☐ Pain on urination	☐ blood in urine	☐ incomplete urination	☐ Increased libido	☐ Impotence
☐ frequent urination	☐ difficulty holding	☐ Wake to urinate	☐ Decreased libido	☐ Premature ejaculation
☐ urgent urination	urine		☐ Kidney stone	☐ Nocturnal emission

For Women

Age menses began:	Duration of flow:	☐ Vaginal discharge	☐ Breast lumps	Date of last PAP:
		Colour?	# pregnancies:	
Length of cycle (day 1 to	☐ Irregular periods	☐ Vaginal sores	# live births:	Date last period began:
day 1	☐ Painful periods	☐ Vaginal odor	# premature births:	
	☐ PMS	☐ Clots	Age at menopause:	

Please indicate any injuries, inflammations and scars. Remember to include scars from any surgeries including laparoscopy, tonsillectomy, appendectomy, episiotomy, cesarean section, tubal ligation, vasectomy, dental work, tattoos, piercings etc. as well as scars from injuries. Please include possible internal scars/inflammations caused by bone breaks, sprains, arthritis, ear, sinus or other infection, IBS, or intestinal dysbiosis.

Front



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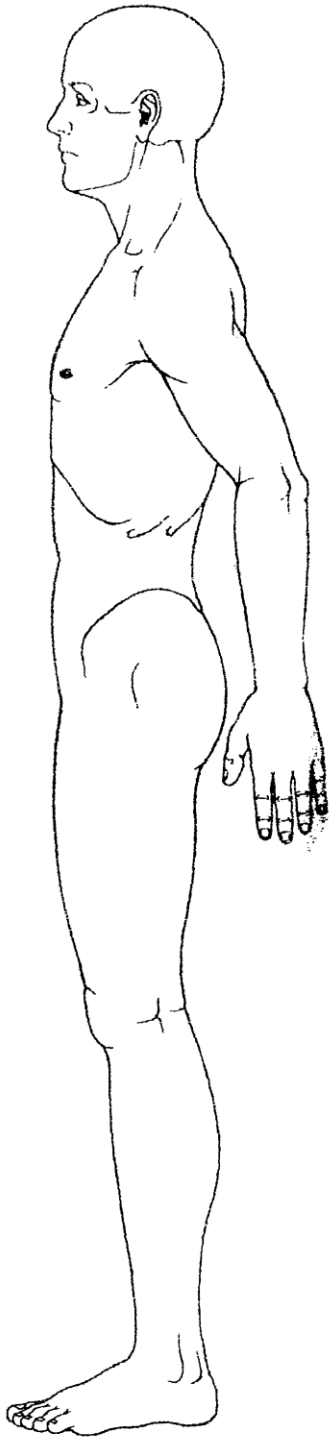

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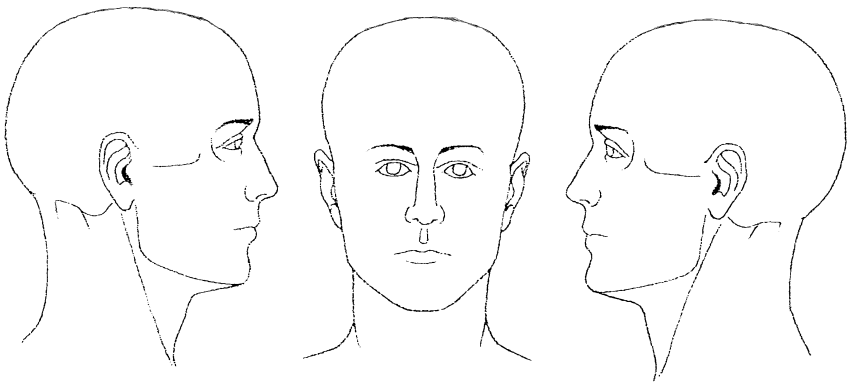

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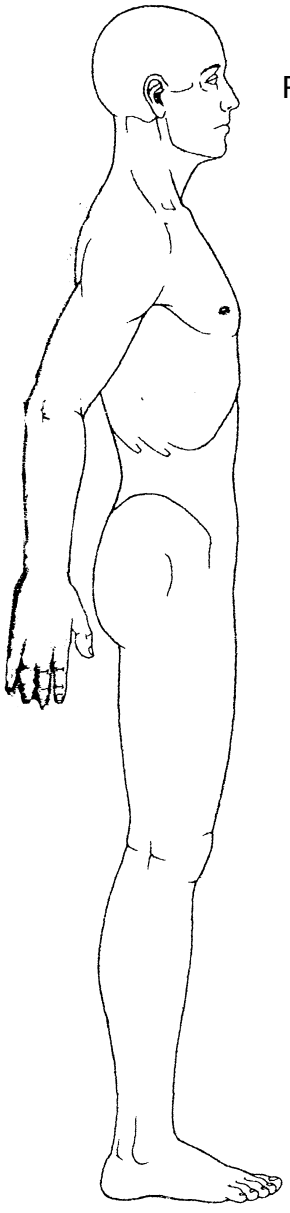

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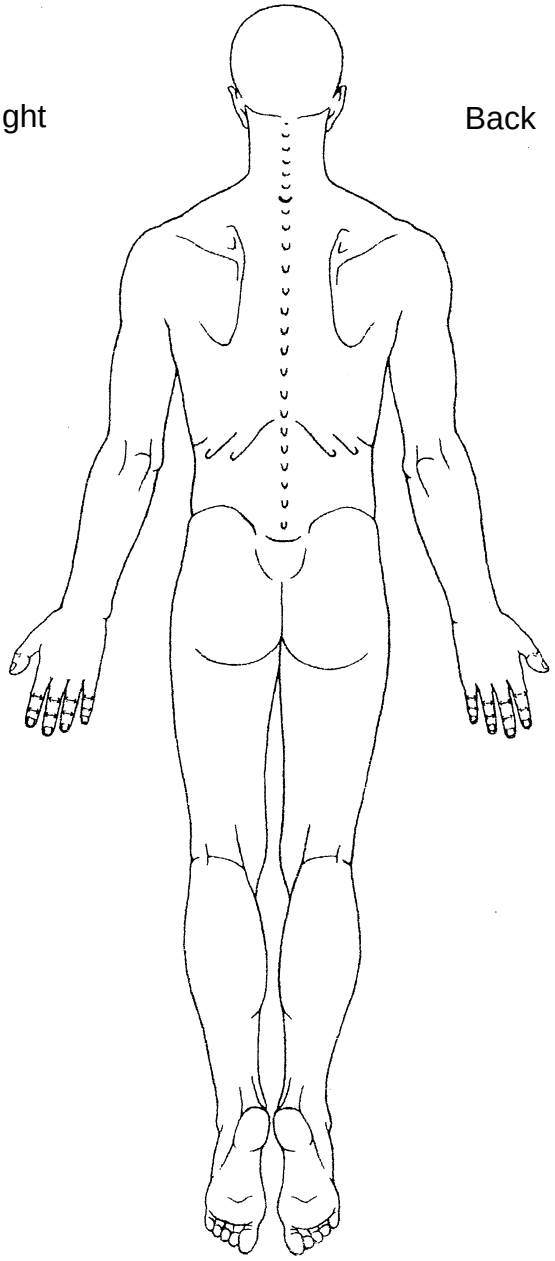

Patient Information and Consent Form

Please read this information carefully and ask your practitioner if their is anything you do not understand.

What is Acupuncture?
Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is acupuncture safe?
Acupuncture is very safe. Serious side effects are very rare: less than one per 10,000 treatments.

Does acupuncture have side effects?
You need to be aware that:

- drowsiness occurs after treatment in a small number of patients, and if affected you are advised not to drive.
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments.
- Pain during treatment occurs in about 1% of treatments.
- Symptoms can get worse after a treatment. (less than 3% of patients) You should tell your acupuncturist about this, but it is usually a sign of a a change in the progression of your illness and considered a good sign in most cases.
- Fainting can occur in some patients, particularly at the first treatment.

Is there anything your acupuncturist needs to know?
Apart from the usual medical details, it is important that you tell your acupuncturist:

- If you have every experienced a seizure or faint
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anticoagulants or any other medication
- If you have damaged heart valves
- If you have any condition that puts you at a higher risk of infection

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Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can stop treatment at any time during an acupuncture session.

Signature _____

Print Name_____ Date:_____