Acupuncture Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Name: _____ Date of First Visit:_____

Date of Birth: _____ M / F Occupation: _____

Address:_____Postal Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email Address_____ Preferred method of contact: Home Cell E-Mail

Family Doctor: _____Phone_____

Emergency Contact Name: _____Phone: _____

How did you hear of us?_____

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

_____

_____

_____

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: _____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _____

_____

_____

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it

_____

_____

_____

_____

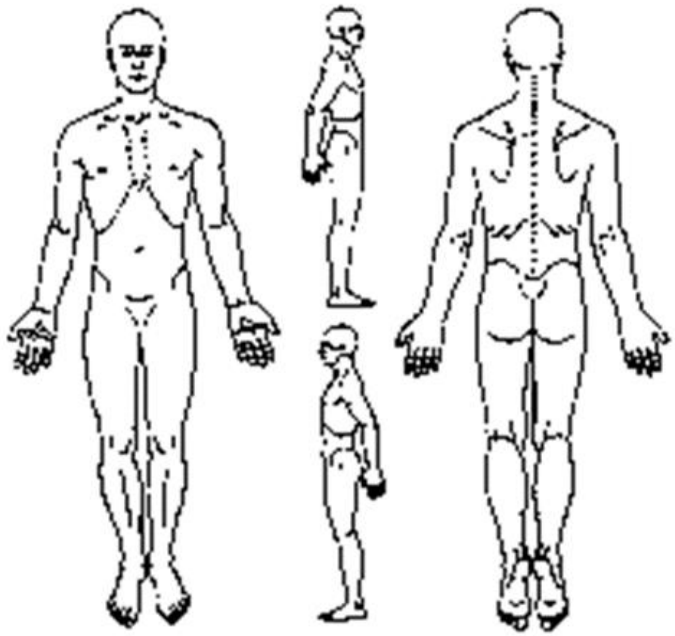
For females: Are you pregnant? NO Possibly YES How far along? _____

Do you have a contagious disease at this time? NO YES: _____

If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

Pain Condition #1 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

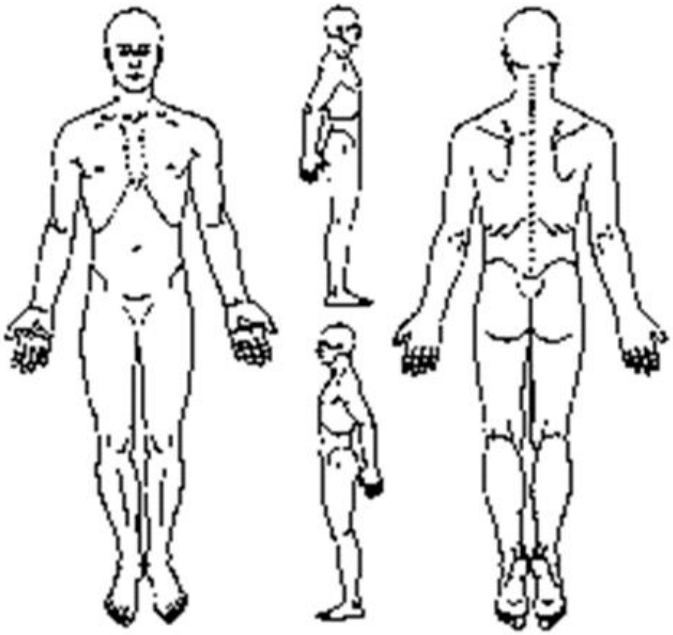
Nature of the Pain
O Constant
O Comes and goes
O Fixed
O Moves
O One side
O Both sides
O Sharp
O Dull
O Burning
O Aching
O Spastic
O Numb



Does the pain get better, or worse with?
O Heat *better worse*
O Cold *better worse*
O Motion *better worse*
O Rest *better worse*
O Pressure *better worse*
O Better in *AM* or *PM*?

Pain Condition #2 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain
O Constant
O Comes and goes
O Fixed
O Moves
O One side
O Both sides
O Sharp
O Dull
O Burning
O Aching
O Spastic
O Numb



Does the pain get better, or worse with?
O Heat *better worse*
O Cold *better worse*
O Motion *better worse*
O Rest *better worse*
O Pressure *better worse*
O Better in *AM* or *PM*

Do you have any of the following?

O Pacemaker
O Surgical replacements
O Implants
O Hemophilia
O Sensitive skin
O Fear of needles
O Latex allergy
O Nut allergy
O Other allergy _____

Is There Family History of:

O Alcoholism
O Allergies
O Asthma
O Bleeding disorders
O Cancer
O Depression
O Diabetes
O Heart disease
O High blood pressure
O Kidney disease
O Mental illness
O Seizures
O Stroke
O Other_____

How much do you consume per day of:

Water _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Cigarettes _____
Generally, do you prefer □ warm drinks □ cold drinks □ room temperature drinks?
Do you find that you are □ always thirsty □ rarely thirsty or □ thirsty for sips later in the day?

What are your typical eating habits?

O Skip Meal(s)_____
O Eat in a Rush
O Eat When Not Hungry
O Eat too Fast
O Cannot eat when Worried/Stressed
O Excess Hunger
O No Desire to Eat
O Eat late at night
O Craving specific food(s)_____
O Other: _____

What are your typical sleeping habits?

O Hours slept/night _____
O Fall asleep quickly
O Trouble falling asleep
O Difficulty waking up
O Trouble staying asleep
O Deep sleeper
O Light sleeper
O Frequent dreaming
O Disturbing dreams
O Wake at same time every night _____
O Other _____

How would you describe your energy levels?

O High
O Low
O Normal
O Lethargic
O Hyperactive
O Changes from day to day
O Other _____

Do you have aversion to any of the following?

O Cold
O Wind
O Dampness
O Heat
O Loud Noises
O Crowds
O Other _____

What is your Average Body Temperature?

O Hot
O Cold
O Cold Hands & Feet
O Hotter @ Night
O Colder @ night
O 5 Center Heat
O Hot Joints
O Other _____

General Information

- O Anorexia/Bulimia
- O Chronic Fatigue
- O Chicken Pox
- O Chronic Pain
- O Fibromyalgia
- O Hepatitis _____
- O HIV
- O Herpes/Cold Sores
- O Cancer: _____
- O Other: _____
- O Lupus
- O Lyme disease
- O Meningitis
- O Scarlet Fever
- O Mononucleosis
- O Multiple Sclerosis
- O Rheumatoid Disease
- O Rheumatic Fever
- O Mumps
- O Tuberculosis
- O Thyroid Disease
  - o Overactive
  - o underactive
- O Measles
- O Pneumonia
- O Tonsillitis

Head, Eyes, Ears, Nose and Throat

- O Bitter taste
- O Blurred vision
- O Cataracts
- O Concussions
- O Dry mouth / nose
- O Ear aches
- O Excess phlegm
- O Eye pain or strain
- O Facial pain
- O Glasses or contacts
- O Glaucoma
- O Other: _____
- O Grinding of teeth
- O Goiter
- O Gum problems
- O Headaches
- O Hearing aids
- O Itchy eyes
- O Migraines
- O Nose bleeds
- O Poor hearing
- O Red or dry eyes
- O Ringing in ears
  - o High pitch
  - o Low pitch
- O Sinus issues
- O Spots in eyes
- O Swollen glands
- O Teeth issues
- O TMJ Syndrome
- O Trigeminal neuralgia
- O Watery eyes

Respiratory:

- O Asthma/Wheezing
- O Frequent colds
- O Allergies
- O Bronchitis
- O Cough
- O Other: _____
- O Cough + Phlegm
- O Emphysema
- O Heavy Chest
- O Pneumonia
- O COPD
- O Cough + blood
- O Difficult breathing
- O Tight Chest
- O Short of Breath

Cardiovascular:

- O Anemia
- O Arteriosclerosis
- O Easily bruised
- O Poor circulation
- O Blood clots
- O Heart Disease: _____
- O Other: _____
- O Fainting
- O High cholesterol
- O Low blood pressure
- O Palpitations
- O Chest pain
- O High blood pressure
- O Irregular heart beat
- O Pace maker
- O Phlebitis
- O Stroke

Gastrointestinal

- O # Bowel Movements/day___
- O Normal Stool
- O Loose stool
- O Constipation
- O Diarrhea
- O Undigested food in stool
- O Mucous in stool
- O Blood in stool
- O Strong odour
- O Pain before BM
- O Other: _____
- O Pain after BM
- O Heartburn/acid reflux
- O Abdominal pain
- O Appendicitis
- O Bloating
- O Celiac Disease
- O Gas
- O Hiccups
- O Nausea/vomiting
- O Bad breath
- O Rectal pain/itching
- O Hemorrhoids
- O Hernia
- O Liver Disorder
- O Ulcer
  - o H. Pylori Negative
  - o H. Pylori Positive
  - o Not Tested

Genito-Urinary

- O Bed wetting
- O Bladder infections
- O Bloody urine
- O Frequent urination
- O Painful urination
- O Incomplete urination
- O Incontinence
- O Urgent urination
- O Wake to urinate
- O Pale urine
- O Dark urine
- O Cloudy urine
- O Kidney stones
- O Kidney Disease
- O Libido issues
- O Yeast infection
- O Impotence
- O Prostate Disorder
- O Premature ejaculation
- O Nocturnal emissions
- O Other: _____

Gynecological

- O Menopause
- O Oral Birth control pills
- O Intra-Uterine Device IUD
- O Breast lumps
- O Genital burning
- O Genital itching
- O Genital discharge
- O Genital swelling
- O Hysterectomy
- O Endometriosis
- O Fibroids
- O Cysts
- O PMS – headaches
- O PMS – back aches
- O PMS – mood swings
- O # Pregnancies _____
- O # Miscarriages_____

Menstruation Information:

- O Heavy periods
- O Light periods
- O Irregular periods
- O Pain Before
- O Pain During

Describe the menstrual blood:

- O Pain After
- O Dark Red
- O Bright Red
- O Pale Red
- O Brownish
- O Thin/Watery
- O Very thick
- O Clots?
  - o Size _____
  - o Color _____

Days between periods _____ # days of period_____

Other Information: _____

Skin and Hair

- O Acne
- O Burning skin
- O Dandruff
- O Dermatitis
- O Discolorations
- O Eczema
- O Fungal infection
- O Hair loss
- O Hot flashes
- O Heavy sweating
- O Not able to sweat
- O Hives
- O Itchy/dry skin
- O Psoriasis
- O Rashes
- O Shingles
- O Warts
- O Other: _____

Neuro-Psychological

- O ADD/ADHD
- O Addiction
- O Anxiety
- O Depression
- O Easily stressed
- O Epilepsy
- O Irritability
- O Mental illness
- O numbness
- O “Foggy” feeling
- O Poor coordination
- O Parkinson’s Disease
- O Poor memory
- O Seizure
- O Vertigo/Dizziness
- O Other: _____

Musculoskeletal:

- O Osteoarthritis
- O Rheumatoid arthritis
- O Atrophy
- O Body heaviness
- O Joint pain
- O Limited motion
- O Limited use
- O Back pain
- O Muscle pain
- O Muscle cramps
- O Neck pain
- O Rib pain
- O Scoliosis
- O Weight gain
- O Weight loss
- O Broken Bones: _____
- O Other: _____