Patient's Intake Form (Acupuncture)

Date: ____________________

Contact Information

Last Name: ___________________________ First Name: ______________________________ Sex: M / F

Date of Birth (DD/MM/YYYY): __________________ Age: _____

Address: _____________________________________ City: ___________________ Postal Code: __________

Phone: (Home) ___________________ (Cell) ___________________ Email: _____________________________

Occupation: __________________ Work Phone: __________________

Living Arrangement: □ Single; □ Married; □ Live in Partner; □ Other No. of Children: _______

Family Physician (Name): ____________________________________ Phone #: ______________________

Emergency Contact (Name): __________________________________ Phone #: ______________________

Referred by: _____________________ □ Media; □ Yellow Pages; □ Other

Chief Complaint

What is your major health concern? ____

When did it begin? ____ Year(s) ____ Month(s) ____ Day(s)

How did it begin? _________________________________

What is the location of your concern? (specify) ____

What other treatment(s) are you currently seeing or have you tried for this health concern?

□ Physician □ Physiotherapy □ Massage □ Acupuncture/TCM □ Chiropractor □ Others: ______________

Have you tried acupuncture before? Yes / No Have you ever taken Chinese herbs before? Yes / No

Medical History (Please check if you have been diagnosed the any of the following):

□ Heart Disease	□ Stroke	□ Seizures	□ High / Low Blood Pressure
□ Lung Disease	□ Asthma	□ Allergies	□ Dermatitis / Skin Problem
□ Liver Disease	□ Hepatitis	□ Migraines	□ Thyroid Disease
□ Kidney Disease	□ Diabetes	□ Arthritis	□ Bleeding Problem
□ Vision Concern	□ Cancer	□ STD	□ Menstrual Concern
□ HIV/AIDS	□ Others: ______________________________		

Have you ever had any surgeries or been hospitalized? If yes, please list with the date(s)?

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Are you allergied to or sensitive to any foods or medications? If yes, please list.

____

Please list any medication you are currently taking including the dosage and the length of use.
(including anitbiotics, antidepressants, anti-inflammatory, steroids, laxatives, oral contraceptives, etc.)

____

Do you or have you ever smoked? If yes, for how long? ___________

Do you exercise regularly? Yes / No

Continue on next page...

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Do you experience any of the following conditions? (Check all that apply)

- □ Palpitation
- □ Chest Pain / Stiffness
- □ Poor Memory/Concentration
- □ Insomnia
- □ Dream disturbed sleep
- □ Irritability
- □ Shortness of breath
- □ Asthma
- □ Cough (dry or with sputum)
- □ Spontaneous sweating
- □ Night Sweating
- □ Feeling cold/hot easily
- □ Feeling hot on hands & feet
- □ Alternating Cold & Hot
- □ Dry mouth & throat
- □ Thristy easily

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- □ Abdominal distension
- □ Hypochondria Pain
- □ Emotional / Moodiness
- □ Depression / Anxiety
- □ Bitter taste in mouth
- □ Feeling a lump in throat
- □ Painful period
- □ Headache / Migraine
- □ Dizziness
- □ Nausea / Vomiting
- □ Belching / Hicup
- □ Dry skin
- □ Eczema / skin rashes
- □ Dry / Itchy eyes
- □ Blurred Vision
- □ Numbness/ tingling
- □ Brittle nails

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- □ Tiredness / Low in Energy
- □ Frequent colds and flu
- □ Feeling heaviness
- □ Poor / Excessive Appetite
- □ Bloating / gas after eating
- □ Heartburn
- □ Tendency to gain weight
- □ Constipation
- □ Diarrhea / Loose Stool
- □ Blood in urine / stool
- □ Difficulty in urination
- □ Frequent Urination
- □ Tinnitus / Hearing Problem
- □ Weak knees & lower back
- □ Knee/Lower back pain
- □ Decreased libido

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FOR FEMALES ONLY:

□ Pregnancies: ____________; □ Abortions____________; □ Miscarriages: __________________;

□ Do you have your period? Yes / No

□ Duration of the period (days):__________________; □ How many days between pe riods: _____

□ Premenstrual tension

□ Excessive uterine bleeding; □Amenorrhea; □ Vaginal discharge (yellow/white/ clear/ green)

□ Infertility; □ Uterine prolapse □ Are you experiencing menopausal symptoms? Yes/ No

□ Have you gone through menopause already?

What is your stress level? □ Minimal □ Average □ Considerable □ High

Please list any other health issued you wish to discuss: ____

What is your main health goal? ____

* Should you need to cancel or reschedule your appointment, we require at least 24 hrs of notice to avoid being charged.
* No show or late cancellation (less then 24hrs) will result in a 50% non-refundable charge.

By Signing this form I am consenting to a complete consultation, diagnosis, evaluation and treatment in accordance with the principles of Traditional Chinese Medicine (TCM).

Patient's Signature: ________________________________ Date: ______________________

- End -