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Traditional Chinese Medicine Acupuncture

Initial Intake Form

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information **Today's date** _____ (d/m/y)

Name_____
Address_____
street city province postal code
Phone numbers (please mark * next to preferred contact number):
Home_____Work_____(etx)._____Cell_____
E-mail address _____
Would you like news from our clinic (mail/email) of updates & health information? Y / N
Date of Birth_____ (d/m/y) Age_____ Gender: F/M

Occupation (1)_____hrs/wk_____ Occupation (2)_____ hrs/wk_____
Health Insurance_____
How did you hear about us? _____
If via person, name:_____ ** discounts are offered with referrals*

Emergency Contact
Name_____ Ph_____ Relationship_____

Under 16 - Responsible Party Information
Name_____ Relationship to Patient _____

Physicians	**Name**	**contact:**
❑ Physicians: GP/Primary Care		
❑ Physicians: OB-GYN		
❑ Physicians: Specialist (describe)		

May I contact these providers to ensure coordination of your care? Y / N

Other Health Care - indicate those you work with, how often (name – optional)

- ❑ Psychologist _____
- ❑ Psychiatrist _____
- ❑ Chiropractic _____
- ❑ Physiotherapy _____
- ❑ Massage therapy _____
- ❑ Naturopathic _____
- ❑ Homeopathic _____
- ❑ Craniosacral _____
- ❑ Osteopathy _____
- ❑ Acupuncture _____
- ❑ Nutrition _____
- ❑ Personal Trainer _____
- ❑ Medical Qigong _____
- ❑ Midwife / Doula _____
- ❑ Other: _____

Previous experience with acupuncture? Y / N

With whom (optional)?_____

Modalities used:

□ Acupuncture □ Acupressure □ Tuina massage □ Cupping □ Moxabustion □ Electro stimulation □ TDP Lamp (heat therapy) □ Herbs □ Gua Sha

Results?_____

Adverse reactions?_____

Health Personal and Family History

Please check boxes of symptoms that you are currently experiencing ☑ and fill in boxes of those that your experienced in the PAST ■ / indicate beside the boxes if any of these conditions apply to a member of your immediate: F (father), M (mother), S (siblings), C (children)

□ Addiction(s), if so to what: _____
□ Alcoholism
□ Allergies
□ Asthma
□ Attempted suicide
□ Birth Trauma
□ Bleeding disorder
□ Blood disease
□ Cancer or tumor
□ Chicken pox / □ Shingles
□ Diabetes
□ Emphysema
□ Eating disorder
□ Gallbladder disorder /stones
□ Fibromyalgia
□ Food sensitivities
□ Heart disease
□ Hepatitis/Liver disease
□ Herpes
□ High blood pressure
□ HIV/AIDS
□ HPV
□ Immune disorder
□ Joint injury
□ Joint replacement
□ Kidney disorder /stones
□ Low blood pressure
□ Lyme's disease
□ Lymph nodes removed
□ Measles
□ Mental illness
□ Multiple Sclerosis
□ Mononucleosis
□ Mumps
□ Osteoarthritis
□ Pacemaker
□ Polio
□ Rheumatic arthritis
□ Rheumatic fever
□ Sciatica
□ Seizures/Epilepsy
□ Sinus infections
□ Skin disease
□ Special diet_____
□ Stroke
□ Substance abuse
□ Thyroid disease
  □ Hyperthyroid function
  □ Hypothyroid function
□ Tuberculosis
□ Ulcer
□ Venereal Disease/STD
□ Other_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had; serious diseases, injuries, surgeries, hospitalizations, other:

Date Event Still affected by this? If so please describe

_____

_____

_____

_____

_____

_____

Medications, Herbs, Supplements (List those you are currently taking):

Name (Brand) Reason Duration/Dosage

1._____
2._____
3._____
4._____

Lifestyle Habits

Describe your typical daily diet:

Breakfast _____
Lunch_____
Dinner _____
Snacks _____
Special diet _____

Drink water	Y/N	Cups (8oz)/day?	_____
Eat out often?	Y/N	Times/week?	_____
Drink coffee?	Y/N	Cups/day?	_____
Drink tea?	Y/N	Cups/day?	_____
Drink soft drinks?	Y/N	Cups/day?	_____
Drink alcohol?	Y/N	Glasses/week?	_____

Do you crave any particular foods (sweet, salty, greasy, sour, bitter, other)? _____

Circle Yes or No or fill in the blank where needed:

Have a supportive relationship? Y/N
Have a history of abuse? Y/N
If yes, would you like to discuss this within your acupuncture sessions? Y/N
What is the major source of joy in your life? _____
_____
What is the major source of stress in your life?_____
_____

Enjoy your work? Y/N Take vacations? Y/N
Spend time outside? Y/N Hours/week?_____
Exercise? Y/N Hours/week?_____
Describe exercise(s):_____

What do you to relax (TV, music, read books, computer, Meditation, Yoga, Qigong, Taichi, other)?
_____
What do you over do?_____
What do you want to do more often? _____
What are your health goals? _____
_____
What would be help or prevent you from meeting your health goals? _____
_____
Please circle your level of commitment to your health issues? (10 = highest level) 1 2 3 4 5 6 7 8 9 10

Recent tests (EKG, Blood Pressure, Sugar levels, Pap smears, Immunizations...)

Please list the test, dates and results of the most recent:

1._____
2._____
3._____

Primary Concern Details

What is your primary concern or symptom: _____
_____
When did this start/happen? _____
_____
What brought this on? _____
_____
How would you describe the symptom or problem?_____
_____

- How often and when:_____
- Quality:(fixed, moving, all over, sharp, dull, achy, throbbing, burning, other):_____

What makes it feel better and/or worst? *(pressure, cold, heat, rest, fatigue, stress , sitting, walking, other.)*

- Better?_____
- Worse?_____

Have you sought any treatment for it? **Y / N**
If yes, what kind?_____
Did it work?_____

Have you had any tests, x-rays, CAT scans, MRI's or blood work done for this issue? **Y / N**
What were the results?_____

Secondary Concern Details

What is your secondary concern or symptom: _____
_____
When did this happen/start? _____
_____
What brought this on? _____
_____
How would you describe the symptom or problem?_____
_____

- How often and when:_____
- Quality:(fixed, moving, all over, sharp, dull, achy, throbbing, burning, other):_____

What makes it feel better and/or worst? *(pressure, cold, heat, rest, fatigue, stress ,sitting, walking, other)*

- Better?_____
- Worse?_____

Have you sought any treatment for it? **Y / N**
If yes, what kind?_____
Did it work?_____

Have you had any tests, x-rays, CAT scans, MRI's or blood work done for this issue? **Y / N**
What were the results?_____

Please check boxes of symptoms that you are currently experiencing ☑ and fill in boxes of those that your experienced in the PAST ■ Also fill in or circle options where applicable.

General Symptoms

Sleep (___hrs/night?)__pm/__am
- ❑ Hard to fall asleep
- ❑ Wake up often /why:_____
- ❑ Dream disturbed
- ❑ Wake up rested
- ❑ Hard to get out of bed
- ❑ Nap during the day

Energy (scale of 1 to 10)
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Sweat
- ❑ Night Sweats / Sweats
- ❑ Daytime sweat / profuse sweat

Other
- ❑ Fever / Chills
- ❑ Cold (hands / feet/ all over)
- ❑ Hot (where?)_____
- ❑ Dizziness (often?)_____
- ❑ Fainting (often?) _____
- ❑ Water retention:_____

E.E.N.T.
- ❑ Cataracts /Glaucoma
- ❑ Blurred or loss of vision
- ❑ Floaters
- ❑ Eye (pain, red, itchy, dry)?
- ❑ Contacts
- ❑ Ringing in the ears (high / low)
- ❑ Earache
- ❑ Deafness or diminishing earring
- ❑ Speech problems
- ❑ Sore throat
- ❑ Difficulty swallowing

Immune system
- ❑ Colds / Flu often
- ❑ Allergies
- ❑ Sensitive to environment
- ❑ Slow to heal

Skin
- ❑ Sensitive
- ❑ Rashes/ itching / dryness
- ❑ Bruise easily
- ❑ Psoriasis / Eczema
- ❑ Boils / hives
- ❑ Contagious condition (herpes, cold sores, other?)_____

Respiratory
- ❑ Do / did you smoke? Y/ N
  #/day _____ # yrs_____
- ❑ Chronic cough
- ❑ Spitting up phlegm / blood
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Sinus problems

Cardiovascular
- ❑ Heart murmur
- ❑ Heart disease
- ❑ History of heart attack
- ❑ Pacemaker / other device
- ❑ High / Low blood pressure
- ❑ Stroke
- ❑ Angina
- ❑ Arteriosclerosis
- ❑ Bleeding disorders
- ❑ Varicose veins
- ❑ Phlebitis
- ❑ Swelling of ankles
- ❑ Poor circulation

Gastrointestinal
- ❑ Poor appetite

Cravings: sweets/ starch/ other
- ❑ Indigestion
- ❑ Stomach pain
- ❑ Ulcer
- ❑ Nausea
- ❑ Vomiting / blood
- ❑ Belching / gas
- ❑ Bloating
- ❑ Distended
- ❑ Gall bladder trouble
- ❑ Hiatus / inguinal hernia
- ❑ Crohn's / Colitis
- ❑ Irritable Bowel

Bowel Movements
- How many times per day?_____
- feels complete?_____
- ❑ Constipation (dry, hard pellets?)
- ❑ Diarrhea (watery or sticky?)
- ❑ Haemorrhoids

Genitourinary
- ❑ Painful urination
- ❑ Difficulty urinating
- ❑ Blood in urine
- ❑ Color (pale, dark)
- ❑ Profuse urination
- ❑ Kidney / bladder infection
- ❑ Stones
- ❑ Incontinence
- ❑ Prostate problems

Gynecological
- ❑ Yeast infection
- ❑ inflammation/conditions
  Describe:_____

<u>Menstruation</u>
- ❑ Regular
- ❑ Short cycle (____days)
- ❑ Long cycle (____days)
- ❑ Irregular
- ❑ Periods (____days)

Flow
- ❑ Normal / Heavy / Scant
- ❑ Clots (small or larger)
- ❑ Color (pale/ light red / dark red)

Cramps: (before / during / after)
(sharp / stabbing / dull / achy)
- ❑ backache
- ❑ swollen breast
- ❑ mood swing

Menopause
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Breast swollen / lumps

<u>Reproductive</u>
- ❑ Pregnant
  - due date_____
- ❑ Trying to get pregnant
- ❑ Pregnancies (_____#)
- ❑ Children (_____#)
- ❑ Miscarriage (_____#)
- ❑ Infertility issues

Describe:_____
- ❑ Birth control pill
  - what type?_____
- ❑ Sexual dysfunction (pain, sex drive, pain, impotence, other?)

Describe:_____

Headache / Migraine

- ❑ Headaches
  Frequency?_____
  Triggers?_____
  Alleviates?_____
- ❑ Migraine
  Frequency?_____
  Triggers?_____
  Alleviates?_____

*Please indicate on figure below where you feel headaches and migraines

Psychosocial

- ❑ Daily Stress:

- work: mild / moderate / high
- personal: mild / moderate / high

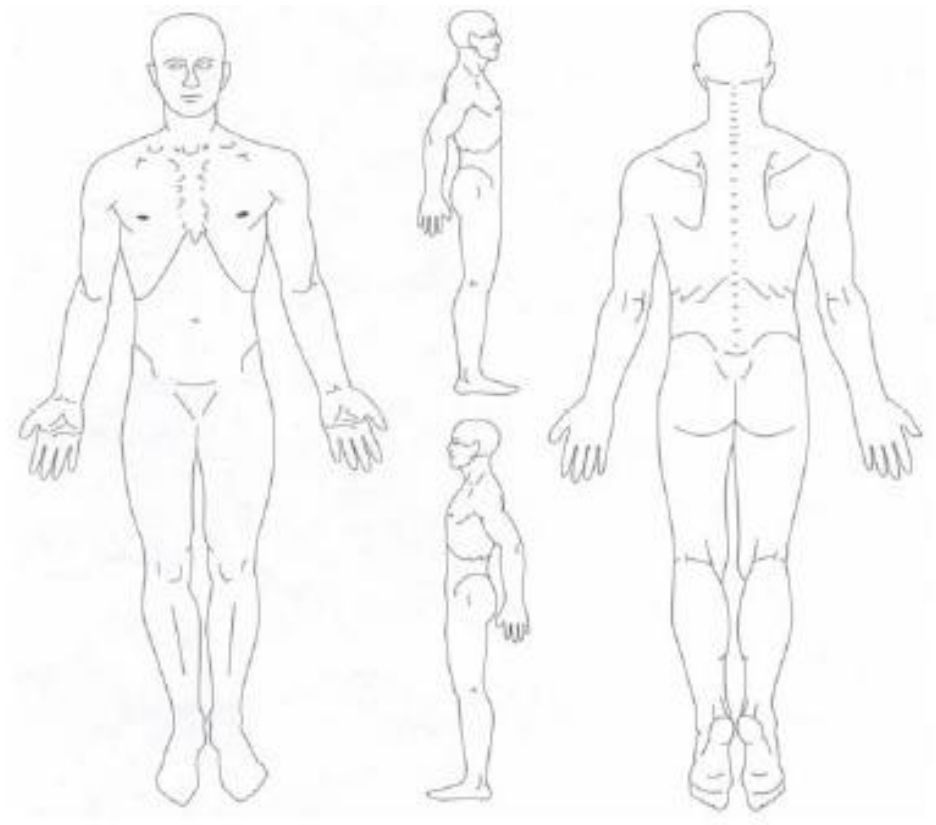
- ❑ Emotional crisis
- ❑ Depression
- ❑ Anxiety
- ❑ Grief / Sadness
- ❑ Fear
- ❑ Nervous / Restless
- ❑ Anger
- ❑ Indecisive
- ❑ Poor memory / concentration
- ❑ Other:_____

Muscles & Joints (stiff/pain)

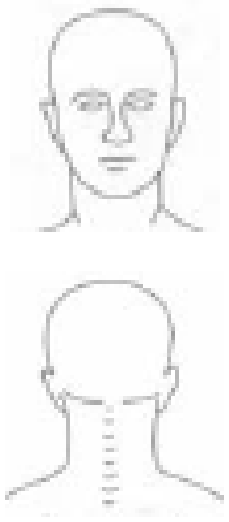
- ❑ Neck
- ❑ Back: upper / lower
- ❑ Shoulder
- ❑ Elbow
- ❑ Wrist / Hand
- ❑ Hip
- ❑ Knee
- ❑ Ankle / Foot
- ❑ Arthritis RA / OA
- ❑ Swollen joints
- ❑ Fractures
- ❑ Jaw problems
- ❑ Muscles weakness / pain

Please draw the location of your pain or discomfort on the images below. Use the symbols to represent which type(s) they are:

D = Dull
S = Sharp / Stabbing
B = Burning
C = Cramping
T = Tingling (Pins and Needles
N = Numb
F = Fixed
M = Moving



Please indicate Headaches / Migraine or other head pain or discomfort patterns below



_____

Patient Signature Date

_____

Witness Signature Date Clinic location

Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, facial rejuvenation acupuncture techniques, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, Japanese hot stone therapy, heat therapy (TDP lamps, heating pads), ear seeds, herbal prescriptions, herbal topical liniments, creams and oils, dietary advice and lifestyle counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, stone therapy and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion, firer cupping and hot stones therapies are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Frequent, regular treatment is what gives acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial during pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for; treatments, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

_____

Patient Signature Date

_____

Witness Signature Date Clinic location