



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 _____ (ext). _____ 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 you 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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Addiction(s), if so to what: _____ | <input type="checkbox"/> Hepatitis/Liver disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> HPV | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Immune disorder | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Joint injury | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Cancer or tumor | <input type="checkbox"/> Kidney disorder /stones | <input type="checkbox"/> Special diet _____ |
| <input type="checkbox"/> Chicken pox / <input type="checkbox"/> Shingles | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme's disease | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lymph nodes removed | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Measles | <input type="checkbox"/> Hyperthyroid function |
| <input type="checkbox"/> Gallbladder disorder /stones | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Hypothyroid function |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal Disease/STD |
| | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> 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 do 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 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 you experienced in the PAST Also fill in or circle options where applicable.

<p>General Symptoms</p> <p>Sleep (___hrs/night?)__pm/___am</p> <p><input type="checkbox"/> Hard to fall asleep</p> <p><input type="checkbox"/> Wake up often /why:_____</p> <p><input type="checkbox"/> Dream disturbed</p> <p><input type="checkbox"/> Wake up rested</p> <p><input type="checkbox"/> Hard to get out of bed</p> <p><input type="checkbox"/> Nap during the day</p> <p>Energy (scale of 1 to 10)</p> <p>Poor 1 2 3 4 5 6 7 8 9 10 Excellent</p> <p>Sweat</p> <p><input type="checkbox"/> Night Sweats / Sweats</p> <p><input type="checkbox"/> Daytime sweat / profuse sweat</p> <p>Other</p> <p><input type="checkbox"/> Fever / Chills</p> <p><input type="checkbox"/> Cold (hands / feet/ all over)</p> <p><input type="checkbox"/> Hot (where?)_____</p> <p><input type="checkbox"/> Dizziness (often?)_____</p> <p><input type="checkbox"/> Fainting (often?) _____</p> <p><input type="checkbox"/> Water retention:_____</p> <p>E.E.N.T.</p> <p><input type="checkbox"/> Cataracts /Glaucoma</p> <p><input type="checkbox"/> Blurred or loss of vision</p> <p><input type="checkbox"/> Floaters</p> <p><input type="checkbox"/> Eye (pain, red, itchy, dry)?</p> <p><input type="checkbox"/> Contacts</p> <p><input type="checkbox"/> Ringing in the ears (high / low)</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Deafness or diminishing earring</p> <p><input type="checkbox"/> Speech problems</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p>Immune system</p> <p><input type="checkbox"/> Colds / Flu often</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Sensitive to environment</p> <p><input type="checkbox"/> Slow to heal</p> <p>Skin</p> <p><input type="checkbox"/> Sensitive</p> <p><input type="checkbox"/> Rashes/ itching / dryness</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Psoriasis / Eczema</p> <p><input type="checkbox"/> Boils / hives</p> <p><input type="checkbox"/> Contagious condition (herpes, cold sores, other?)_____</p>	<p>Respiratory</p> <p><input type="checkbox"/> Do / did you smoke? Y/ N #/day _____ # yrs_____</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Spitting up phlegm / blood</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Sinus problems</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> History of heart attack</p> <p><input type="checkbox"/> Pacemaker / other device</p> <p><input type="checkbox"/> High / Low blood pressure</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Bleeding disorders</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Poor circulation</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Poor appetite</p> <p>Cravings: sweets/ starch/ other</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting / blood</p> <p><input type="checkbox"/> Belching / gas</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Distended</p> <p><input type="checkbox"/> Gall bladder trouble</p> <p><input type="checkbox"/> Hiatus / inguinal hernia</p> <p><input type="checkbox"/> Crohn's / Colitis</p> <p><input type="checkbox"/> Irritable Bowel</p> <p>Bowel Movements</p> <p>- How many times per day?_____</p> <p>- feels complete?_____</p> <p><input type="checkbox"/> Constipation (dry, hard pellets?)</p> <p><input type="checkbox"/> Diarrhea (watery or sticky?)</p> <p><input type="checkbox"/> Haemorrhoids</p>	<p>Genitourinary</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Difficulty urinating</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Color (pale, dark)</p> <p><input type="checkbox"/> Profuse urination</p> <p><input type="checkbox"/> Kidney / bladder infection</p> <p><input type="checkbox"/> Stones</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Prostate problems</p> <p>Gynecological</p> <p><input type="checkbox"/> Yeast infection</p> <p><input type="checkbox"/> inflammation/conditions</p> <p>Describe:_____</p> <p>Menstruation</p> <p><input type="checkbox"/> Regular</p> <p><input type="checkbox"/> Short cycle (___days)</p> <p><input type="checkbox"/> Long cycle (___days)</p> <p><input type="checkbox"/> Irregular</p> <p><input type="checkbox"/> Periods (___days)</p> <p>Flow</p> <p><input type="checkbox"/> Normal / Heavy / Scant</p> <p><input type="checkbox"/> Clots (small or larger)</p> <p><input type="checkbox"/> Color (pale/ light red / dark red)</p> <p>Cramps: (before / during / after)</p> <p>(sharp / stabbing / dull / achy)</p> <p><input type="checkbox"/> backache</p> <p><input type="checkbox"/> swollen breast</p> <p><input type="checkbox"/> mood swing</p> <p>Menopause</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Breast swollen / lumps</p> <p>Reproductive</p> <p><input type="checkbox"/> Pregnant</p> <p>- due date_____</p> <p><input type="checkbox"/> Trying to get pregnant</p> <p><input type="checkbox"/> Pregnancies (___#)</p> <p><input type="checkbox"/> Children (___#)</p> <p><input type="checkbox"/> Miscarriage (___#)</p> <p><input type="checkbox"/> Infertility issues</p> <p>Describe:_____</p> <p><input type="checkbox"/> Birth control pill</p> <p>- what type?_____</p> <p><input type="checkbox"/> Sexual dysfunction (pain, sex drive, pain, impotence, other?)</p> <p>Describe:_____</p>
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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

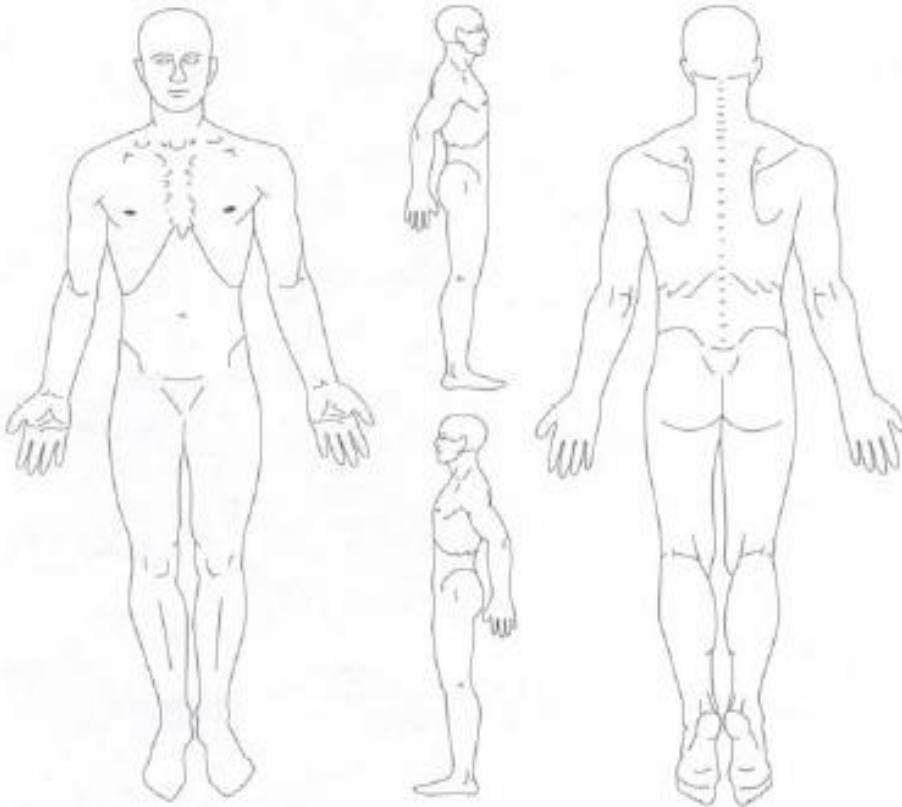
Please draw the location of your pain or discomfort on the images below. Use the symbols to represent which type(s) they are:

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 _____