Confidential Acupuncture Personal Intake Form

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Please note that Chinese Medicine views the body as an intricate relationship between organs and systems. In order to fully understand your condition, it is important that you take the time to fill out this form.

Personal details:

Date: _____

Date of birth: _____ Contact number: _____

Prefix: Dr. Mr. Mrs. Ms. Miss. Cell: _____

_____

(Last Name) (First Name) (Initials)

_____

(Address) (City) (Province) (Postal Code)

Gender: Male / Female

Occupation: _____

E-mail address: _____

How did you hear about us? : _____

Family physician:

Name of Medical Doctor: _____

Phone Number: (_____)_____-_____

Address: _____

Date of Last Visit: _____/_____/_____

(YYYY) (MM) (DD)

Emergency contact:

Name: _____

Relationship: _____

Daytime Phone: (_____)_____-_____ Evening Phone: (_____)_____-_____

All records are kept confidential and are not part of a medical records copied to other medical intuitions.

Medical History and Information:

Please list all medications you are currently taking (include vitamins and over the counter medication): -

_____

_____

If female, when was your last cycle? _____

A. If female, are you currently pregnant? Yes / No / Unsure / N/A

B. If female, how many pregnancies have you had? _____

C. If female, have you ever had a miscarriage? Yes / No
   a. Number of miscarriages: _____

D. Are you currently using birth control? Yes / No
   a. Type of birth control: _____
   b. How long have you been using birth control: _____

Any previous surgeries/hospital admissions:

Please list to the best of your ability the times you have been hospitalized:

Date	Illness/Procedure	Hospital

Do you have any skin or mesh grafts, implants, plates, pins, or pacemakers?

_____

_____

Have you been diagnosed or are you currently receiving any form of treatment for Cancer? Yes / No

c. Type of cancer(s): _____
d. Types and methods of treatment(s):

_____

_____

Allergies/Sensitivities

_____

_____

_____

Reason for visit:

Please list your primary health concerns/chief complaints:

_____
_____
_____
_____

Of which of these concerns is the most important to you? How long has this been a concern?

_____

What do you think has caused this problem?

_____
_____

How does this effect your daily activities?

- ☐ It does not affect them
- ☐ I have had to stop doing some of them
- ☐ I have had to change how I do things
- ☐ I am unable to perform most activities

Which of the following treatments, if any, have you already received for you concern?

- ☐ Medication
- ☐ Chiropractic
- ☐ Physical Therapy
- ☐ Acupuncture
- ☐ Massage
- ☐ Other _____

Additional points of concern:

_____
_____
_____

Traditional Chinese Medicine - Please check any of the follow that pertain to you:

Lung Function:

- ☐ Cough
- ☐ Dry nose
- ☐ Dry Skin
- ☐ Headache
- ☐ Smoke cigarettes
- ☐ Nose bleeds
- ☐ Sneezing
- ☐ Dry throat
- ☐ Nasal discharge (colour) _____
- ☐ Dry mouth
- ☐ Sinus congestion
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Alternating fevers & chills

Stomach Function:

- ☐ Acid regurgitation
- ☐ Large appetite
- ☐ Ulcer (previously diag.)
- ☐ Mouth sores (cankers)
- ☐ Burning sensation after eating
- ☐ Heartburn
- ☐ Bad breath
- ☐ abdominal pain
- ☐ Excessive gas
- ☐ Bleeding, swollen and or painful gums

Spleen Function:

- ☐ Low appetite
- ☐ Sudden weight loss
- ☐ Overthinking
- ☐ Gurgling noises in the stomach
- ☐ Prolapsed organs (Which organ?) _____
- ☐ Worry
- ☐ abrupt weight gain
- ☐ Pensive
- ☐ Fatigue after eating
- ☐ Easily bruised

Heart:

- ☐ Palpitation
- ☐ Mental confusion
- ☐ Drink Coffee/Tea (# of cups/day) _____
- ☐ Anxiety
- ☐ waking unrefreshed
- ☐ Restlessness
- ☐ frequent dreams

Liver + Gallbladder Function:

- ☐ Chest pain
- ☐ Unable to adapt to stress
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Limited Range of Motion (neck)
- ☐ Headache at the top of the head
- ☐ Gallstones (past or current)
- ☐ Anger easily
- ☐ Frustration
- ☐ Bitter taste in mouth
- ☐ Red Eyes
- ☐ Limited Range of Motion (shoulder – Left or right)
- ☐ Skin rashes (location :_____)
- ☐ Alternating diarrhea + constipation
- ☐ Irritability
- ☐ Depression
- ☐ Neck tension
- ☐ Ringing in the ears (High Pitch)

Kidney Function:

- ☐ Heat in hands, feet, chest
- ☐ Night sweats
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Cold feet
- ☐ Lack of perspiration
- ☐ Thirsty
- ☐ ringing in the ears (Lo Pitch)
- ☐ Perspire easily
- ☐ Hot body temp
- ☐ Cold body temp Cold hands
- ☐ Difficulty keeping eyes open during the day
- ☐ Hot flashes
- ☐ Afternoon flushes

Urinary Bladder/Urination:

- ☐ Normal Colour
- ☐ Profuse
- ☐ Dark yellow
- ☐ Strong odour Bladder I
- ☐ Infections
- ☐ Clear
- ☐ Burning
- ☐ Cloudy
- ☐ Reddish
- ☐ easily startled
- ☐ Scant
- ☐ Urgent
- ☐ Painful
- ☐ Frequent
- ☐ Wake during the night

Gastrointestinal System:

- ☐ Irritable bowel
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Bowel movement's ____X day
- ☐ Constipation
- ☐ Colitis
- ☐ Abdominal cramps
- ☐ Crohn's Disease

Overall:

- ☐ Excess phlegm
- ☐ Frequent Cold & Flu
- ☐ Preference for hot drinks
- ☐ Preference for cold drinks
- ☐ Low energy
- ☐ High energy
- ☐ typically run hot
- ☐ typically run cold

Blood/Insect Borne and Sexually Transmitted Diseases

Please check all that apply, experiencing or past. Any misinformation can result in termination of treatment, among legal complications.

- ☐ HIV/Aids
- ☐ Encephalitis
- ☐ Herpes
- ☐ Trichomonas
- ☐ Hepatitis B
- ☐ Genital Warts
- ☐ Malaria
- ☐ Hepatitis C
- ☐ Tuberculosis (TB)
- ☐ Pelvic Inflammatory Disease
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Other:

Please list how often you smoke and/or use alcohol:

_____

_____

Consent to Acupuncture Treatment

I, _____, herby consent to the performance of acupuncture and other procedures related to acupuncture as deemed necessary, including moxibustion, cupping, and or electro acupuncture by the below noted registered acupuncturist.

I understand and I am informed that in the practice of acupuncture there are some risks to treatment. Including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsion, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Ear Acupressure/Auriculotherapy: Are small seeds, metal beads or ear tacks that are attached to the ear by adhesive tape. The seeds can stay on the ear for 3-5 days. The Pressure from the seeds might be quite painful, and the patient is advised to press the acupoints several times a day to reach the maximum effect. If any itchiness or rash occurred on the ear, the patient should immediately remove the tape and seeds/metal beads.

I have read the above consent form. I have also had an opportunity to ask questions about its content. By signing below, I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

Date: _____ Patient Signature: _____

Female Patients only:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture/auriculotherapy treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Date: _____ Patient Signature: _____

Cancellation and Time policy

We Value your time, we will call you if we are running more than 15 minutes behind. We request that you call the clinic if you are running 15 min behind as well. We also require a 24 hour cancellation notice. Missed appointments or late cancellations are subject to a fee of $35.00. **Please Initial:** _____

Practitioner Signature: _____ Date: _____

Andrea Low R.Ac, Licence Number 2892