Acupuncture Comprehensive Initial Intake Form

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Please note that this is a comprehensive intake form, with many questions which may seem unrelated to your primary concern(s). Do not feel obligated to go into excessive detail over things which you do not care to have addressed. Though be aware, that the more information available, the better we are able to see a clear picture, and tailor the most effective treatment possible.

Personal Information

Name:___________________________________	Gender/Sex:_____________________
Birth Date: D_____/M_____/Y___________	Age: _____________________________
Address:_________________________________	City:____________ Province:______
Email:___________________________________	Postal Code:_____________________
Phone:__________________________________	

Emergency Contact	Phone:
Primary healthcare provider:	Phone:
How did you hear about us?	

Primary health concern:
Secondary health concern(s):
Past or present medical treatment for the above:
Diagnoses
Insurer____________________, Plan/Policy #________________ ID #_______________________

Personal Medical History

Illnesses ____

____

Surgeries (and dates)____

____

Significant Trauma: (and dates - i.e. motor vehicle accidents, fractures, etc.)

____

____

Do you have a history of current or past infectious disease? Y / N

Please describe____

Medicines (please list all medications, herbs, vitamins and over the counter drugs)

____

____

Allergies/Sensitivities (foods, drugs, medications or environmental factors)

____

____

General (please check all that apply)

☐ Poor Appetite	☐ Weakness	☐ Sudden Energy Drops
☐ Hearing Loss	☐ Fevers	☐ Chills
☐ Easy to Bleed/Bruise	☐ Sweat Easily	☐ Fatigue
☐ Strong Thirst	☐ Poor Sleep	☐ Tremors
☐ Puffiness or Swelling	☐ Poor Balance	☐ Weight Loss
☐ Night Sweats	☐ Cravings	☐ Weight Gain
☐ Changes in Appetite	☐ Other:________________________________	

Skin & Hair

☐ Rashes	☐ Itching	☐ Dandruff
☐ Skin Ulcers	☐ Eczema	☐ Hair Loss
☐ Hives	☐ Pimples	☐ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Toothache
- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Ear Ringing
- ☐ Sinus Problems
- ☐ Taste/Smell Problems
- ☐ Headaches
- ☐ Concussions
- ☐ Eye Strain/Pain
- ☐ Night Blindness
- ☐ Poor Hearing
- ☐ Nose Bleeds
- ☐ Facial Pain
- ☐ TMJ Pain
- ☐ Migraines
- ☐ Ear Aches
- ☐ Spots in Eyes
- ☐ Recurrent Sore Throat
- ☐ Lip or Tongue Sores
- ☐ Floaters

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet
- ☐ Blood Clots
- ☐ Palpitations
- ☐ Swelling of Hands
- ☐ Swelling of Feet
- ☐ Chest Pain
- ☐ Phlebitis
- ☐ Fainting
- ☐ Lightheadedness

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty Breathing
- ☐ Phlegm
- ☐ Coughing Up Blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Painful Breathing
- ☐ Easily Winded

Gastro-Intestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bad Breath
- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Chronic Laxative Use
- ☐ Vomiting
- ☐ Intestinal Gas
- ☐ Indigestion
- ☐ Rectal Pain
- ☐ Belching
- ☐ Blood in Stools
- ☐ Hemorrhoids

Urology

- ☐ Painful Urination
- ☐ Urgency to Urinate
- ☐ Incontinence
- ☐ Decreased Flow
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Kidney Stones
- ☐ Frequent Night Urination
- ☐ Pain in Groin Area
- ☐ Sexually Transmitted Disease

Neuro-Psychological

- ☐ Seizures
- ☐ Areas of Numbness
- ☐ Concussion
- ☐ Twitches
- ☐ Lack of Coordination
- ☐ Depression
- ☐ Irritability
- ☐ Loss of Balance
- ☐ Stress
- ☐ Poor Memory
- ☐ Anxiety
- ☐ Mood Swings
- ☐ Tremors

Gynecology ***if applicable***

Menarche(1st menses) age________

Duration of Menses ______________

Date of Last Menses _____________

# of Pregnancies _________________

# of Births_________________________

☐ Irregular Periods
☐ Painful Periods
☐ Breast Lumps
☐ Spotting
☐ Vaginal Discharge

☐ Clots
☐ PMS
☐ Menopausal
☐ Yeast Infection
☐ Fertility Issues

Musculo-Skeletal

☐ Arthritis
☐ Muscle Spasms
☐ Pain with Weather
☐ Muscle Weakness
☐ Scoliosis
☐ Pain with Activity
☐ Muscle Cramping
☐ Weak Joints
☐ Pain After Waking

Frequently Asked Questions

What is acupuncture?

Acupuncture is a therapeutic method used to encourage natural healing, reduce or relieve pain and improve function of affected areas of the body. It involves the insertion of very fine sterile 1x use needles through the skin and tissue at specific parts of the body.

How does it work?

Acupuncture stimulates the body to produce its own pain relieving chemicals called Endorphins. Endorphins help to block the pathways that relay pain messages from the body to the brain resulting in pain relief. It improves energy and biochemical balance thereby stimulating the body's natural healing abilities, decreasing inflammation and promoting physical and emotional well-being.

Are there any side effects?

Acupuncture is a very safe modality; however the following are possible side effects that you may experience:

-minor bleeding or bruising

-temporary aggravation of symptoms (in less than 3% of patients)

-fainting (particularly if the patient has never had acupuncture before, and is anxious)

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

- I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on patient named below, for whom I am legally responsible) by the below named registered acupuncturist and/or other registered acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back- up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.
- I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, tui-na (Chinese massage), guasha, qigong exercise and stretch instruction, Chinese or Western herbs, and nutritional counseling.
- I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel, the nature and purpose or acupuncture treatments and other procedures.
- Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of pneumothorax. There may be some bruising after cupping or guasha.
- The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.
- I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form.

- I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
- I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

I confirm that I have read and understood the above information including the risks and benefits of acupuncture. I understand that I can refuse treatment at any time.
by signing below, I consent 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.

Print Name	Signature	Date