



# ACUPUNCTURE - INTAKE

Please answer all questions to the best of your ability and as truthfully as possible. This form is confidential.

Reason(s) for Visit: (E.g. Headaches)	Onset: (Eg. Oct 31)	Frequency: (E.g. 2x/week)	Severity: (E.g. Scale 1-10)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Past Medical History: (E.g. Heart attack) \_\_\_\_\_  
\_\_\_\_\_

Family Medical History: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother/Sister: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Surgeries (Major/Minor): (E.g. Metal implants; pacemaker) \_\_\_\_\_  
\_\_\_\_\_

Injuries (Recent/Old): \_\_\_\_\_  
\_\_\_\_\_

Lifestyle Habits:

Tobacco: ( ) Y ( ) N Packs/Day: \_\_\_\_\_

Alcohol: ( ) Y ( ) N Drinks/Day/Week: \_\_\_\_\_

Caffeine: ( ) Y ( ) N Cups/Day: \_\_\_\_\_

Marijuana: ( ) Y ( ) N Per Week: \_\_\_\_\_

Other Recreational Drugs: ( ) Y ( ) N \_\_\_\_\_  
\_\_\_\_\_

Allergies: (E.g. Latex) \_\_\_\_\_  
\_\_\_\_\_

Medications & Supplements: \_\_\_\_\_  
\_\_\_\_\_

What do you do for Physical Activity: (E.g. running) \_\_\_\_\_  
\_\_\_\_\_



# ACUPUNCTURE - INTAKE

Please answer all questions to the best of your ability and as truthfully as possible. This form is confidential.

What do you do to Relax: \_\_\_\_\_  
\_\_\_\_\_

How's your sleep: (Insomnia, wake up frequently, etc.) \_\_\_\_\_  
\_\_\_\_\_

Major Stressors in Life: \_\_\_\_\_  
\_\_\_\_\_

Typical Diet Throughout Day: \_\_\_\_\_  
\_\_\_\_\_

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Cravings: (E.g. sweet, salty) \_\_\_\_\_  
\_\_\_\_\_

Water Consumption/Day: \_\_\_\_\_  
\_\_\_\_\_

## DIGESTION

### Typical diet:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Indigestion               | <input type="checkbox"/> Cramping               | <input type="checkbox"/> Gas                    |
| <input type="checkbox"/> Bloating                  | <input type="checkbox"/> Burping                | <input type="checkbox"/> Poor appetite          |
| <input type="checkbox"/> Excessive appetite        | <input type="checkbox"/> Hiccapping             | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Acid reflux               | <input type="checkbox"/> Excessive thirst       | <input type="checkbox"/> Lack of thirst         |
| <input type="checkbox"/> Stools more than 3x a day | <input type="checkbox"/> Many small tiny stools | <input type="checkbox"/> Loose stools           |
| <input type="checkbox"/> Stools with a bad odour   | <input type="checkbox"/> Mucus in the stools    | <input type="checkbox"/> Bloody stools          |
| <input type="checkbox"/> Black stools              | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Abnormal weight loss      | <input type="checkbox"/> Abnormal weight gain   |   |



# ACUPUNCTURE - INTAKE

Please answer all questions to the best of your ability and as truthfully as possible. This form is confidential.

## URINATION:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blood in Urine      | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Chronic UTI's       | <input type="checkbox"/> Genital Itching    | <input type="checkbox"/> Dribbling after   |
| <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Bright Yellow      | <input type="checkbox"/> Dark Yellow       |
| <input type="checkbox"/> Bright Yellow Clear | <input type="checkbox"/> Other              |  |

## SKIN

- |                                    |  |                                   |
|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Oily skin | <input type="checkbox"/> Dry skin          | <input type="checkbox"/> Acne     |
| <input type="checkbox"/> Rashes    | <input type="checkbox"/> Hives             | <input type="checkbox"/> Eczema   |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Shingles |

## HAIR

- |  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Premature greying | <input type="checkbox"/> Premature balding | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Oily hair         | <input type="checkbox"/> Other             |                                   |

## PAIN

- |   |                                   |                                 |
|---|-----------------------------------|---------------------------------|
| <input type="checkbox"/> <b>Headaches and Migraines</b> | <b>Location:</b>                  |                                 |
| <input type="checkbox"/> Throbbing                      | <input type="checkbox"/> Pounding | <input type="checkbox"/> Dull   |
| <input type="checkbox"/> Tingling                       | <input type="checkbox"/> Shooting | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Sharp                          | <input type="checkbox"/> Tight    | <input type="checkbox"/> Other: |
| <input type="checkbox"/> <b>Pain in the Body</b>        | <b>Location:</b>                  |                                 |
| <input type="checkbox"/> Throbbing                      | <input type="checkbox"/> Pounding | <input type="checkbox"/> Dull   |
| <input type="checkbox"/> Tingling                       | <input type="checkbox"/> Shooting | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Sharp                          | <input type="checkbox"/> Tight    | <input type="checkbox"/> Other: |

## NOTES:

---

---

---

---

---



# ACUPUNCTURE - INTAKE

Please answer all questions to the best of your ability and as truthfully as possible. This form is confidential.

## MOOD AND LIFESTYLE

- Depressed or apathetic
- Irritable
- Angry
- Forgetful
- Unclear or "fuzzy" thinking
- High stress lifestyle

## SLEEP

- Always tired
- Lots of dreams
- Frequent nightmares
- Insomnia
- wake up early
- fall asleep late or restless sleep

## LUNGS AND CHEST

- Cough with blood and/or phlegm
- Dry cough
- Wet cough
- Shortness of breath
- Chest pain
- Asthma

## HEART

- Palpitations
- High blood pressure
- Low blood pressure

## EYES

- Red, burning and/or itchy eyes
- Blurred vision
- Poor night vision
- Sensitive to light
- Poor hearing with no explanation
- Ringing ears

## MOUTH AND NOSE

- Mouth ulcers
- Gum problems
- Dry mouth and/or throat
- Hoarse voice
- Nosebleeds

## NEUROLOGICAL SYMPTOMS

- Seizures
- Tremors
- Muscle weakness
- Paralysis
- Hemiplegia
- Loss of balance
- Dizziness
- Vertigo
- Autoimmune disease

## NOTES:

---

---

---

---

---

# ACUPUNCTURE - INTAKE

**INDICATE WHERE YOU HAVE PAIN**

**X - SHARP**

**D - DULL**

**N - NUMBNESS**

**T - TINGLING**

**NOTES:**

---



---



---



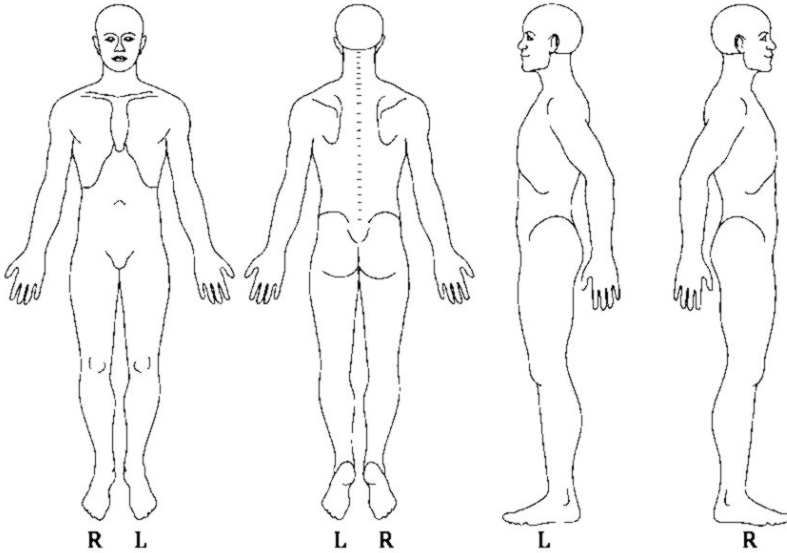
---



---



---



**WOMEN ONLY: - Menstrual History**

Age of first period: \_\_\_\_\_ Periods Regular: ( ) Y ( ) N Days between periods: \_\_\_\_\_

Duration of Period: \_\_\_\_\_ Do you bleed between cycles? ( ) Y ( ) N

PMS Symptoms:	None	Before	During	Mid Cycle
Emotional	( )	( )	( )	( )
Breast Swelling	( )	( )	( )	( )
Breast Tenderness	( )	( )	( )	( )
Back Pain	( )	( )	( )	( )
Acne	( )	( )	( )	( )
Headaches	( )	( )	( )	( )
Bloating	( )	( )	( )	( )
Cramps	( )	( )	( )	( )

Are you using a Contraceptive? ( ) Y ( ) N

What Type: \_\_\_\_\_

History of Pregnancies: \_\_\_\_\_



# ACUPUNCTURE - INTAKE

Please answer all questions to the best of your ability and as truthfully as possible. This form is confidential.

## WOMEN'S HEALTH - General women's health

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cysts                       | <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Lower libido than usual |
| <input type="checkbox"/> Higher libido than usual    | <input type="checkbox"/> Vaginal dryness            | <input type="checkbox"/> Infertility             |
| <input type="checkbox"/> Excessive vaginal discharge | <input type="checkbox"/> Uterus or vaginal collapse | <input type="checkbox"/> Painful intercourse     |

## Menstruation

Colour: \_\_\_\_\_

Pain: \_\_\_\_\_

Flow: \_\_\_\_\_

Last period \_\_\_\_\_ days ago

Average cycle \_\_\_\_\_ days or irregular

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Cramping between periods | <input type="checkbox"/> Breast lumps        |
| <input type="checkbox"/> Breast tenderness        | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Birth control pills |
| <input type="checkbox"/> Clots                    |   |  |

## Menopause

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Premenopausal | <input type="checkbox"/> Perimenopause   | <input type="checkbox"/> Postmenopausal |
| <input type="checkbox"/> Hot flashes   | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Mood swings    |
| <input type="checkbox"/> Night sweats  | <input type="checkbox"/> Insomnia        | <input type="checkbox"/> Depression     |

## Pregnancy and Conception

Are you pregnant?  Y  N

Are you trying to become pregnant?  Y  N

History of miscarriage?  Y  N

4 or more pregnancies  Y  N

## MEN'S HEALTH

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Infertility           | <input type="checkbox"/> Impotence | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Premature ejaculation |                                    |   |



# CONSENT TO ACUPUNCTURE TREATMENT

I, \_\_\_\_\_ hereby fully understand the acupuncture treatment process and the possible side effects such as: bruising, needle site discomfort, dizziness, fainting, post-acupuncture sensation (numbness, tingling, heaviness, tiredness), and temporary exacerbation of symptoms. Rare and unusual risks include infection, nerve damage, organ puncture, excessive bleeding, and spontaneous miscarriage.

I agree to fully disclose all past and current health conditions, including all medications I am currently taking. I have had the opportunity to discuss the nature and purpose of the treatment and ask any questions I may have. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications that may occur as a result of treatment. I understand that there are no guarantees regarding improvement or cure of my condition. I give consent to have acupuncture treatment, as well as any other treatments in the scope of Traditional Chinese Medicine that the acupuncturist has explained and recommended for me. These may include but are not limited to: herbal medicine, auricular treatment, moxibustion, cupping, and electro-stimulation.

Alberta Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless that person has already consulted with a physician or in the case of dental pathology, a dentist, about the condition for which care and treatment from the acupuncturist is being sought; that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; the acupuncturist has completed a patient consultation form. I confirm that I have consulted with a physician or dentist about the condition for which acupuncture treatment is being sought.

_____	Date: _____ 20__
Patient Signature	
_____	Date: _____ 20__
Witness Signature	
_____	Date: _____ 20__
Patient/Guardian Signature	