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:	Onset:	Frequency:	Severity:
(E.g. Headaches)	(Eg. Oct 31)	(E.g. 2x/week)	(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) _____

_____

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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:

( ) Indigestion
( ) Cramping
( ) Gas
( ) Bloating
( ) Burping
( ) Poor appetite
( ) Excessive appetite
( ) Hiccupping
( ) Nausea and/or vomiting
( ) Acid reflux
( ) Excessive thirst
( ) Lack of thirst

( ) Stools more than 3x a day
( ) Many small tiny stools
( ) Loose stools
( ) Stools with a bad odour
( ) Mucus in the stools
( ) Bloody stools
( ) Black stools
( ) Diarrhea
( ) Constipation

( ) Abnormal weight loss
( ) Abnormal weight gain

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URINATION:

( ) Blood in Urine
( ) Chronic UTI's
( ) Kidney Stones
( ) Bright Yellow Clear
( ) Frequent Urination
( ) Genital Itching
( ) Bright Yellow
( ) Other
( ) Painful Urination
( ) Dribbling after
( ) Dark Yellow

SKIN

( ) Oily skin
( ) Rashes
( ) Psoriasis
( ) Dry skin
( ) Hives
( ) Fungal infections
( ) Acne
( ) Eczema
( ) Shingles

HAIR

( ) Premature greying
( ) Oily hair
( ) Premature balding
( ) Other
( ) Dandruff

PAIN

( ) **Headaches and Migraines** **Location:**
( ) Throbbing ( ) Pounding ( ) Dull
( ) Tingling ( ) Shooting ( ) Aching
( ) S**har**p ( ) Tight ( ) Other:
( ) **Pain in the Body** **Location:**
( ) Throbbing ( ) Pounding ( ) Dull
( ) Tingling ( ) Shooting ( ) Aching
( ) S**har**p ( ) Tight ( ) Other:

NOTES:

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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

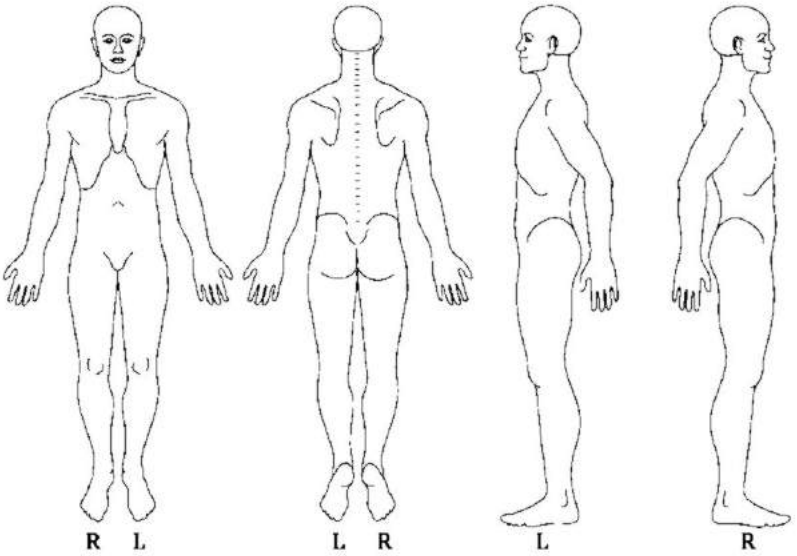
NEUROLOGICAL SYMPTOMS

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

NOTES:

360° WELLNESS 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: _____

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WOMEN'S HEALTH - General women's health

( ) Cysts ( ) Endometriosis ( ) Lower libido than usual

( ) Higher libido than usual ( ) Vaginal dryness ( ) Infertility

( ) Excessive vaginal discharge ( ) Uterus or vaginal collapse ( ) Painful intercourse

Menstruation

Colour: _____

Pain: _____

Flow: _____

Last period_____days ago

Average cycle_____days or irregular

( ) Bleeding between periods ( ) Cramping between periods ( ) Breast lumps

( ) Breast tenderness ( ) PMS ( ) Birth control pills

( ) Clots

Menopause

( ) Premenopausal ( ) Perimenopause ( ) Postmenopausal

( ) Hot flashes ( ) Vaginal dryness ( ) Mood swings

( ) Night sweats ( ) Insomnia ( ) 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

( ) Infertility ( ) Impotence ( ) Erectile dysfunction

( ) Premature ejaculation

360° WELLNESS

CONSENT TO ACUPUNTURE 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