Acupuncture Initial Intake & Consent

*** First Name** _____
*** Last Name** _____
*** Email** _____
Mobile Phone _____
Home Phone _____

Street Address _____
Suite Number _____
City _____
Province _____
Country _____
Postal / Zip _____
Date of Birth _____

Gender/Pronouns _____
Sex _____

Personal Health # _____
Emergency Contact _____
Contact Phone _____
Family Doctor _____
Family Dr. Contact _____
Occupation _____

<u>Questionnaires</u>

Cheif Complaint

_____

_____

SecondaryComplaint(s)

_____

_____

_____

Past or present medical treatment for any of the above?

_____

_____

_____

Diagnoses_____

_____

Current Medications / Supplements

_____

_____

Allergies to Food or Medicine

_____

History of Surgeries/Injuries

_____

_____

Medical History _____

_____

_____

_____

Goals & Expectations for Treatment

_____

_____

_____

Treatment Preferences (personal, religious, spiritual, etc.)

_____

_____

Please list types of activity/exercise you engage in, as well as how many hours/week

_____

_____

_____

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Special Precautions

- ❑ blood thinners
- ❑ pacemaker or ICD
- ❑ implanted electric medical device
- ❑ pregnant
- ❑ trying to get pregnant
- ❑ HIV
- ❑ hepatitis
- ❑ communicable disease
- ❑ antidepressants
- ❑ anti-anxiety medications
- ❑ seizures
- ❑ fainting episodes
- ❑ fear of needles
- ❑ never had acupuncture

Body Temperature / Perspiration

- ❑ I generally feel hot
- ❑ I generally feel cold
- ❑ hot body and cold limbs
- ❑ prefer hot drinks
- ❑ prefer cold drinks
- ❑ cold hands &/or feet
- ❑ hot palms &/or feet
- ❑ hot flashes
- ❑ dry skin
- ❑ lack of sweating
- ❑ excessive sweating
- ❑ spontaneous sweating
- ❑ foul smelling sweat

General

- ❑ general tiredness
- ❑ lack of morning energy
- ❑ weakness of limbs
- ❑ spontaneous sweating
- ❑ poor appetite
- ❑ bearing down sensation in abdomen
- ❑ depression
- ❑ frequent sighing
- ❑ feeling of lump in throat

Sleep

- ❑ I have no sleep issues
- ❑ difficulty falling asleep
- ❑ difficulty staying asleep
- ❑ vivid dreams
- ❑ low energy in morning
- ❑ night time urination
- ❑ history of insomnia
- ❑ daytime drowsiness
- ❑ sleep apnea
- ❑ snoring
- ❑ other

Musculoskeletal

- ❑ back pain
- ❑ neck pain
- ❑ knee pain
- ❑ elbow pain
- ❑ shoulder issues
- ❑ hip issues
- ❑ jaw pain
- ❑ pelvic pain
- ❑ abdominal pain
- ❑ foot/ankle pain
- ❑ muscle weakness
- ❑ repetitive injuries
- ❑ other

Current Pain Description

_____

_____

_____

_____

Pain Scale

1	2	3	4	5
6	7	8	9	10

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Gastrointestinal / Hepatic

- ❑ constipation
- ❑ diarrhea
- ❑ borborygmus (gargling stomach)
- ❑ loose stool
- ❑ undigested stool
- ❑ blood in stool
- ❑ hemorrhoids
- ❑ vomiting
- ❑ heartburn
- ❑ nausea
- ❑ hiatus hernia
- ❑ craving sweet food
- ❑ edema (swelling ankles)
- ❑ food allergies
- ❑ excessive hunger
- ❑ lack of appetite
- ❑ feeling full/heaviness
- ❑ foul breath
- ❑ gallstones
- ❑ upper abdominal pain
- ❑ difficulty digesting greasy foods
- ❑ abdominal/rib side distension

Respiratory

- ❑ shortness of breath
- ❑ asthma
- ❑ cough
- ❑ sinus infections
- ❑ environmental allergies
- ❑ diminished sense of smell
- ❑ skin problems
- ❑ spitting phlegm
- ❑ nose bleeds
- ❑ rattling sound with voice
- ❑ dry skin

Genitourinary / Reproductive

- ❑ urinary frequency
- ❑ difficulty urinating
- ❑ waking to urinate
- ❑ blood in urine
- ❑ painful urination
- ❑ kidney stones
- ❑ frequent UTI's
- ❑ dribbling after urination
- ❑ decreased libido
- ❑ impotence
- ❑ infertility
- ❑ night sweats

Cardiovascular

- ❑ palpitations
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ dizziness
- ❑ easily startled
- ❑ shortness of breath on exertion
- ❑ stuffiness in chest
- ❑ chest-pain
- ❑ chest tightness
- ❑ stabbing chest pain
- ❑ swollen ankles

Head, Ears, Eyes, Nose Throat

- ❑ mouth ulcers
- ❑ decreased vision
- ❑ floaters in vision
- ❑ blurry vision
- ❑ eye pain
- ❑ dry eyes
- ❑ headaches
- ❑ migraines
- ❑ concussions
- ❑ night blindness
- ❑ facial pain
- ❑ tinnitus (ringing in ears)
- ❑ poor hearing
- ❑ nose bleeds
- ❑ nasal drainage
- ❑ glasses
- ❑ tonsils removed
- ❑ tongue ulcers

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Mental Health

- ❏ stress
- ❏ irritability
- ❏ timidity
- ❏ anxiety
- ❏ history of panic attack
- ❏ dream disturbed sleep
- ❏ mental restlessness
- ❏ depression
- ❏ racing thoughts
- ❏ overthinking
- ❏ family history of mental health
- ❏ poor memory
- ❏ you do have adequate support
- ❏ you do not have adequate support

Current Stress Level

1	2	3	4	5
6	7	8	9	10

Female Health

- ❏ irregular periods
- ❏ history of miscarriage
- ❏ prolonged period (> 5 days)
- ❏ short period (< 3 days)
- ❏ delayed period
- ❏ painful periods
- ❏ PMS
- ❏ excessive bleeding
- ❏ minor bleeding
- ❏ abnormal cell growth on cervix
- ❏ birth control
- ❏ pregnant
- ❏ trying to get pregnant
- ❏ perimenopausal
- ❏ post-menopausal

Do you use any of the following

- ❏ Coffee
- ❏ Marijuana
- ❏ Tobacco
- ❏ CBD
- ❏ Pain Relievers

Email Communication

- ❏ I would like email notifications of new, canceled, and rescheduled appointments
- ❏ Email 2 days before appointment
- ❏ Text Message (SMS) 2 hours before appointment
- ❏ News and Special Promotions
- ❏ Yes, I would like occasional updates and special offers via email. No more frequent than once monthly.

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- ❏ I certify that the above medical information is correct to my knowledge.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged the full fee of their appointment.
I am aware of the Cancellation Policy

Signature_____

Date_____