Lisa Gallant RA.c, Natural Path Wellness Centre, 463-9351, fax: 463-3524 massage@naturalpathwellness.ca

Acupuncture and Traditional Chinese Medicine

Intake Form

Please fill out this questionnaire to ensure the best possible care. All information is kept confidential. Please ask if you need assistance. Thank you[1]

Name: ______________________________________Date: ___________________

Address: ____

Email: _______________________________Home Phone: ___________________

Work Phone: _____________

Age: _______ Date of Birth: _________________________ Sex M/F:____

Occupation:____________________________Employer:______________________

Emergency Contact:_____________________________Phone:_________________

Physician: ____________________________________ Phone:_________________

Have you received acupuncture therapy before? Y / N (date)__________

Main problem/s you would like help with

1. ______________________________
2. ______________________________
3. ______________________________

When did the problem(s) begin?

Have you been given a diagnosis for the problem(s)? If so, what?

What kind of treatments have you tried?

Daily living

Please indicate usage per day or per week:

Water ______ glasses per day

Coffee ______ cups per day/week (circle)

Tea ______ cups per day/week (circle)

Alcohol ______ day/week Type liquor/beer/wine

Soft Drinks ______ day/week

Cigarettes ______ day/week

Sweets ______ day/week

____

Diet and exercise

Please describe your general diet:

Breakfast:

Lunch:

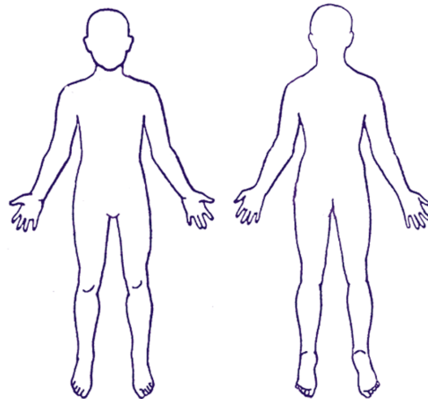
Dinner:

Snacks:

Please indicate how many times you exercise per week, and briefly describe your typical routine:

Muscles/ Bones/ Joints

Do you have pain or tightness? No / Yes. If Yes, please indicate the location on the chart below.



Rate your pain on a scale from 1 to 10

No pain 1 2 3 4 5 6 7 8 9 10 ***Extreme pain***

Circle the quality that best describes your pain:

Sharp
Dull
Aching Numb
Burning and/or Tingling
Pain worse in am/pm
Pain worse/better with heat
Pain worse/better with cold
Pain worse/better with pressure

Medical History (Check all that apply):

Please list any past surgeries, and date:

Do you have a pacemaker? Yes/ NIntake form.pageso

Please check any of the following that apply to you, past and present:

__Allergies __Hemophiliac __HIV/ Hepatitis __Anemia __Arteriosclerosis __Asthma __Anorexia __Bleeding Disorders __Bronchitis __Bulimia __Cancer __Candidiasis __Chronic Fatigue __Convulsions __Depression __Diabetes __Eczema __Emphysema __Epilepsy __Gout __Heart disease __Hernia __Herpes simplex 1 __Herpes simplex 2 __High blood pressure __High cholesterol	__Hyperglycemia __Hypoglycemia __Inflammatory Bowel Disease __Jaundice __Kidney disorders __Liver disorders __Low Blood Pressure __Lupus __Menstrual Disorders __Multiple Sclerosis __Osteoarthritis __Parkinson's __Pneumonia __Polio __Prostate Disorders __Psoriasis __Psychiatric Care __Rheumatoid Arthritis __Seizures __Stomach Ulcers __Stroke __Thyroid Disorders __Tonsillitis __Tuberculosis __Urinary Tract Infections __Venereal Disease Other____________

Please write "C" for current or "P" for past in front of conditions that applies to you:

Gastrointestinal

__Nausea/ vomit
__Heartburn
__Ulcer
__Hiccups
__Diarrhea
__Constipation
__Gas and bloating
__Abdominal pain
__Loose stool
__Dry stool
__Blood in stool
__Mucus in stool
__Itching/burning anus

Urinary/ Genital

__Painful/itching genitals
__Painful urination
__Excessive urination
__Urgent urine
__Blood in urine
__Incontinence of urine
__Wakes at night to urinate
__Kidney/bladder stones

Respiratory

__Chronic cough
__Weak cough
__Load cough
__Cough up white phlegm
__Cough up yellow phlegm
__Cough up blood
__Shortness of breath
__Asthma/ Wheezing
__Frequent colds

Cardiovascular/ Circulatory

__Palpitations
__Chest pain
__Irregular heart beat
__Chest pain
__High blood pressure
__Low blood pressure
__Cold hands and feet
__Excessive bleeding
__Easy bruising

Head/ Neck/ Face

__Dizziness/light headed
__Headache/migraine
__Faint
__Neck stiffness
__Jaw pain
__Facial tics
__Facial paralysis

Emotions

__Fearful
__Sadness
__Grief
__Anger/frustration
__Over worry
__Anxious
__Forgetfulness

Muscle/ Joint

__Joint pain
__Body ache and stiffness
__Numbness/tingling
__Heavy body
__Knee pain
__Low back pain

Eyes

__Poor vision
__Blurry vision
__Floaters
__Dry eyes
__Watery Eyes
__Red/itchy eyes

Skin

__Hives/rashes
__Eczema/psoriasis
__Acne
__Night sweats
__Spontaneous sweats
__No sweat
__Dry skin
__Bruise easily
__Brittle/dry nails

Nose/Throat/Mouth

__Sinus infections
__Allergies
__Recurring sore throat
__TMJ
__Excessive thirst
__Lack of thirst
__Mouth ulcers
__Teeth pain
__Prefer warm drinks
__Prefer cold drinks

General

__Insomnia
__Excessive sleep
__Fatigue
__Dizziness
__Numbness
__Frequent chills
__Fever
__Premature hair loss
__Premature greying
__Edema

Men's Health

__Impotence
__Infertility
__Seminal emissions
__Premature ejaculation
__Decreased libido

Women's Health:

Menstruation:

How many days are between your period?_________

Please indicate if you have experienced any of the following between your period:

__ Yellow vaginal discharge

__ White or clear discharge

__ Cramps or pain. If yes, **when**? before/ during/ after

__ Spotting or bleeding between periods

How many days in duration is your period?______

Please indicate the quality/ quantity of blood:

__ Light red

__ Dark red

__ Clotted

__ Heavy flow

__ Normal flow

__ Scanty flow

Do you experience breast tenderness? If yes, when? Where?

Pregnancy:

How many pregnancies have you had?_________

Indicate any pregnancy-related difficulties?____________________________________

Have you had any miscarriages? Yes/ No

Are you currently pregnant? Yes/ No

Are you trying to become pregnant? Yes/ No

Are you using contraceptives? Yes/ No

Menopause:

Please indicate your current status:

__Premenopausal __Perimenopausal __Postmenopausal

At what age did menopause begin?

Please indicate symptoms that apply to you?

*** 24 hours of notice is needed for cancellations. There will be a charge of $25.00 for missed appointments without cancellation. Herbal products are non-refundable after they are opened.**

Patient Signature:__________________________________

Guardian Signature:________________________________

(If patient is under the age of 16)

Date:__________________________

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