



Acupuncture Intake Form

Please bring your completed new patient forms with you to your appointment or arrive 10-15 min prior to your scheduled appointment time (to allow enough time to fill in this Intake form).

Acupuncture is a versatile form of treatment which means that we may be able to address more than one problem area or concern per treatment.

What to Expect

When you come in for your acupuncture treatment you can expect to spend the first few minutes talking. We will talk about your history and your symptoms and how acupuncture will help. I may also take your pulse and examine your tongue- these are useful diagnostic tools in Chinese Medicine. I'll then propose a course of treatment and explain which points I am going to use. The needles are very fine and one use only, so they're safe, sterile and virtually painless to insert. I may also explain and use a few other techniques like Cupping, Gua Sha (manual muscle work), ear acupuncture or electro acupuncture. After that, I leave you to rest and let the needles do their work.

Last Name: _____ First Name: _____ Gender: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone No: _____

Email: _____

Date of Birth: _____ Carecard No: _____

Occupation: _____

Physician: _____ Phone No: _____

Referred by: _____

Emergency Contact Name: _____

Relationship to you: _____ Phone No: _____

How did you hear about the clinic? _____

I would like to be reminded of my upcoming appointments by: Email Text Both Email and Text

If you selected yes to Text appointment reminders, who is your cell phone provider?
(eg: Fido, Telus, Rogers) _____

What is the *main* reason you are coming in today?

When did it start? _____

How does it impact your daily life? _____

Are you currently being treated with chiro/massage/medication? _____

❖ Please indicate if you have any of the following conditions:

- | | | |
|-------------------------|-----------|--------------------------|
| High/Low Blood pressure | Cancer | Blood Clotting Disorders |
| Diabetes | Hepatitis | Liver Disease |
| Neurological Condition | HIV/AIDS | Kidney Disease |
| Spinal or Head Injury | Seizures | Heart/Lung Disease |

Do you take any blood thinning medications? If yes, please specify _____

Are you or do you suspect you might be pregnant? _____

Do you have an implanted device/pacemaker? _____

Are you currently taking any medications, supplements, or vitamins? Please list:

Please indicate your habits:

Glasses of water per day: _____	Coffee/Tea per day/week: _____
Alcohol per day/week: _____	Soft drinks per day/week: _____
Cigarettes per day/week: _____	

Do you exercise? Y/N

If yes, please describe the type of exercise you do: _____

How often? _____

How is your energy level on a scale of 1 to 10? Low 1 2 3 4 5 6 7 8 9 10 High

How is your body temperature on a scale of 1 to 10? Cold 1 2 3 4 5 6 7 8 9 10 Hot

Do you sleep well at night? Y / N How many hours per night do you sleep? _____

Please tick any that apply:

- | | |
|--|---|
| <input type="checkbox"/> I have trouble falling asleep | <input type="checkbox"/> I wake up early |
| <input type="checkbox"/> I wake up during the night frequently | <input type="checkbox"/> I don't feel rested in the morning |

How many bowel movements do you have per day? _____ Please tick any that apply:

- | | |
|--|--|
| <input type="checkbox"/> Well formed early morning stool | <input type="checkbox"/> Alternate loose/hard stools |
| <input type="checkbox"/> Constipation/ Hard Stools | <input type="checkbox"/> Diarrhea/ Loose stools |
| <input type="checkbox"/> Mucous or blood in stools | |

How many times do you urinate per day? _____ Please tick any that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Clear urine | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Dark yellow urine | <input type="checkbox"/> Frequent urination |

How is your digestion?

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Little to no appetite | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Belching | <input type="checkbox"/> Tired after eating |
| <input type="checkbox"/> Heartburn/ Reflux | | |

How is your thirst?

- | | |
|--|---|
| <input type="checkbox"/> Often thirsty | <input type="checkbox"/> Thirsty but no desire to drink |
| <input type="checkbox"/> No thirst | <input type="checkbox"/> Prefer warm/ cold drinks |

Do you sweat? Y / N

- | | | | |
|--|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sweats easily | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> No Sweating |
|--|---------------------------------------|--------------------------------------|--------------------------------------|

Which emotions do you feel frequently?

- | | | | |
|---------------------------------------|--|--------------------------------|---------------------------------|
| <input type="checkbox"/> Joy | <input type="checkbox"/> Sadness/grief | <input type="checkbox"/> Worry | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Anxiety/fear | <input type="checkbox"/> Depression | <input type="checkbox"/> Anger | |

Please Tick any symptoms that you experience regularly:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Aversion to cold | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Pain in rib cage | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Dry skin/hair |
| <input type="checkbox"/> Frequent sighing | <input type="checkbox"/> Cough | <input type="checkbox"/> Brittle nails |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pale lips/nails |
| <input type="checkbox"/> Moodiness | <input type="checkbox"/> Low immunity | <input type="checkbox"/> Ligament/tendon problems |
| <input type="checkbox"/> Pain that comes and goes | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Spots/floaters in eyes | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Eye dryness or pain | |
| <input type="checkbox"/> Aversion to wind | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Agitation/restlessness |
| <input type="checkbox"/> Haemorrhoids | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hot hands/feet |

- | | | |
|---|---|--|
| <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Red cheeks in the afternoon |
| <input type="checkbox"/> Bruise/bleed easily | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Over-thinking | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Low back pain | |
|
 | | |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Change in sexual drive |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Hot joints | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Sock marks on ankles | <input type="checkbox"/> Vivid dreams | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Body pain | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Knee pain |

Gynaecological History (For women only)

Number of pregnancies_____ Number of births_____ Are you pregnant? Y / N

Are you trying to become pregnant? _____

Do you practice birth control? Y / N What kind?_____ For how long?_____

Do you still get your period? Y / N If not, at what age did it cease?_____

How many days is your cycle?_____ How many days does your period last?_____

Please tick any that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Early periods | <input type="checkbox"/> Painful/swollen breasts | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Late periods | <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Cramping | |
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Change in bowel movements | |

Cancellation Policy:

In consideration of other patients and the therapist, I understand that a minimum of 24 hours notice is required to change or cancel my appointment. I am aware that it is my responsibility to pay 50% of the treatment fee in the case of late cancellation or missed appointments. Cancellation fees are payable before rebooking another appointment.

Patient Name_____ Signature_____

Date_____ Witness_____

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

Please read the following information carefully. We'd be happy to clarify anything that is unclear.

I hereby request and consent to the performance of acupuncture and other techniques within the scope of registered acupuncturists such as cupping, electro -acupuncture, and gua sha.

Acupuncture has been shown to be very effective in treating many conditions affecting the physical body and mental/emotional well-being. There are, however, some risks that may arise with these treatments. It is difficult to as a practitioner to anticipate all the possible risks/ complications that may arise with each individual but listed below are some of the more common ones:

- Minor bruising or bleeding
- drowsiness may occur-please be aware that it may affect your ability to drive immediately after treatments
- temporary soreness

Please note that occasionally symptoms may get worse before they get better; these should only last a day or two. If they worsen for longer than two days, please contact your practitioner.

I understand that it is important to provide my acupuncturist with complete information and notify them of any major changes to my health, or any of the following conditions:

- Are you pregnant? Acupuncture can be very beneficial in the treatment of symptoms associated with pregnancy, as well as assisting in birthing preparation and post -partum. Please let us know if you are pregnant or trying to get pregnant
- Do you have a pacemaker or electrical implant?
- Do you have a bleeding disorder?
- Are you taking blood thinners or other medications that affect your clotting time?
- Do you have any medical conditions that increase your risk of infection?
- Are you subject to fainting or feeling faint?

I have read and understood the above information and give my consent to treatment from Sara Irving, R.Ac (Registered Acupuncturist).

Full Name: _____

Signature: _____

Date: _____