Columbia Integrated
Health Centre

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: _____
Alcohol per day/week: _____
Cigarettes per day/week: _____

Coffee/Tea per day/week: _____
Soft drinks 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:

- ☐ I have trouble falling asleep
- ☐ I wake up during the night frequently
- ☐ I wake up early
- ☐ I don't feel rested in the morning

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

- ☐ Well formed early morning stool
- ☐ Constipation/ Hard Stools
- ☐ Mucous or blood in stools
- ☐ Alternate loose/hard stools
- ☐ Diarrhea/ Loose stools

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

- ☐ Clear urine
- ☐ Painful urination
- ☐ Cloudy urine
- ☐ Dark yellow urine
- ☐ Blood in urine
- ☐ Frequent urination

How is your digestion?

- ☐ Little to no appetite
- ☐ Hungry
- ☐ Heartburn/ Reflux
- ☐ Stomach pain
- ☐ Belching
- ☐ Bloating
- ☐ Tired after eating

How is your thirst?

- ☐ Often thirsty
- ☐ No thirst
- ☐ Thirsty but no desire to drink
- ☐ Prefer warm/ cold drinks

Do you sweat? Y / N

- ☐ Sweats easily
- ☐ Night sweats
- ☐ Hot flashes
- ☐ No Sweating

Which emotions do you feel frequently?

- ☐ Joy
- ☐ Sadness/grief
- ☐ Worry
- ☐ Stress
- ☐ Anxiety/fear
- ☐ Depression
- ☐ Anger

Please Tick any symptoms that you experience regularly:

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

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

☐ Irregular periods	☐ Breast lumps	☐ Endometriosis
☐ Early periods	☐ Painful/swollen breasts	☐ Infertility
☐ Late periods	☐ Heavy flow	☐ Bloating
☐ Painful periods	☐ Vaginal discharge	☐ Fibroids
☐ Irritability	☐ Cramping	
☐ Clotting	☐ 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: _____