Patient Intake Form

for Acupuncture Treatment at Infinite Healing

Section A: Your Information

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____

Postal Code: _____ E-mail: _____

Birth date: M_____ D_____ YR_____ Age: _____ ☐ Male ☐ Female

Home Telephone: (____)_____ Cell: (____)_____ Work: (____)_____Ext:_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ # of Children: _____

Business / Employer: _____ Type of Work: _____

Is there any chance you are pregnant? Yes ☐ No ☐

Emergency Contact name:_____ Relation: _____ Phone: (____)_____

Physician:_____ Phone: (____)_____

Do you suffer from any of the following Illnesses:

☐ AIDS ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hepatitis ☐ HIV (+) ☐ Seizures

How did you hear about our office? (If someone referred you, please let us know so that we can thank them!)

_____

Section B: Past Medical History

_____

_____

_____

Section C: Your Current Health

Check any of the following symptoms you have had in the last 12 months, even if they do not seem related to your current problem. Please feel free to mark more than one box in each section if it applies.

Chills & Fever:

☐ Chills ☐ Fever

☐ Morning ☐ Afternoon ☐ Night

If so, please describe (how often, how long) _____

Sweating: ☐ Yes ☐ No

☐ Day ☐ Night ☐ Spontaneous ☐ Slightly ☐ Excessive ☐ Shivering

Location: ☐ Palms ☐ Feet ☐ Head/Face ☐ Body

Other:_____

Head & Body:

Head: ☐ Headache Type of pain: ☐ Sharp ☐ Dull ☐ Pounding

Location:_____ ☐ Worse during the day ☐ Worse during the night

☐ Dizziness ☐ Vertigo ☐ Heaviness ☐ Sudden onset ☐ Gradual onset

Is there anything that makes the headache better or worse (pressure, hot or cold)_____

Body: ☐ Neck pain ☐ Low back pain ☐ Upper back pain ☐ Shoulder pain ☐ Elbow pain

☐ Sciatica ☐ Wrist/hand pain ☐ Knee pain ☐ Ankle/Foot pain ☐ Swelling of limbs

☐ Cold hands/feet ☐ Arthritis ☐ Fatigue

Other: _____

Type of pain (sharp, dull, achy, numbness/tingling, burning, hot, cold,) _____

_____

☐ Cough ☐ Sore throat ☐ Phlegm: If so what colour: ☐ White ☐ Yellow ☐ Blood

☐ Asthma ☐ Wheezing ☐ Shortness of breath

☐ Allergies ☐ Loss of smell ☐ Nosebleeds ☐ Nasal congestion

Other:_____

Skin Problems:

☐ Rashes ☐ Eczema ☐ Acne ☐ Dryness ☐ Itching Other:_____

Urine & Stool:

Urine:

Colour: ☐ Clear ☐ Yellow ☐ Dark ☐ Cloudy ☐ Red

☐ Burning sensation ☐ Painful ☐ Dribbling ☐ Normal ☐ Strong ☐ Weak

☐ Scanty ☐ Normal ☐ Excessive

Odor: ☐ None ☐ Mild ☐ Normal ☐ Strong

Frequency: Per day:_____ Per night: _____

Stool:

Colour: ☐ Yellow ☐ Light-Brown ☐ Brown ☐ Dark-Brown ☐ Black ☐ Red

Odor: ☐ None ☐ Mild ☐ Normal ☐ Strong

☐ Diarrhea ☐ Loose ☐ Watery ☐ Soft ☐ Hard ☐ Dry

☐ Constipation ☐ Painful

Number of bowel movements per day: _____

Is there any undigested food, mucus or blood in the stool? _____

Appetite & Taste:

Appetite:

☐ None ☐ Poor ☐ Good ☐ Excessive

☐ Nausea ☐ Vomiting ☐ Belching ☐ Foul breath ☐ Bloating ☐ Acid Regurgitation

Food Preference: ☐ Hot food ☐ Cold food Other: _____

How many meals per day? _____

Any changes in appetite? _____

Any weight gain or loss? _____

Any other digestive problems? _____

Taste in mouth:

☐ None ☐ Bitter ☐ Sweet ☐ Sour ☐ Salty ☐ Greasy ☐ Hot

☐ Fishy ☐ Foul breath

Taste preference:

☐ None ☐ Bitter ☐ Sweet ☐ Sour ☐ Salty ☐ Greasy

Thirst & Drink:

Thirst:

☐ None ☐ Poor ☐ Good ☐ Excessive

☐ Thirst without desire to drink ☐ Thirst with preference for drink

How much water/fluid do you drink per day? _____

Any preference to hot, cold or room temperature water? _____

Chest & Abdomen:

Chest:

☐ Stifling sensation ☐ Chest pain ☐ Hypochondriac pain (pain on the side) ☐ Sighing

☐ Distention and fullness of chest ☐ Palpitations ☐ Anxiety

Type of pain (sharp, stabbing, dull, achy, heavy, burning, hot, cold,) _____

Does anything make it better or worse (pressure, heat/cold) _____

Do you have difficulty breathing? ☐ Yes ☐ No If so, please describe _____

_____

Abdomen:

Do you experience abdominal distention and/or pain? ☐ Yes ☐ No

If so, where? (upper, middle, lower) _____ How often? _____

Does anything make it feel better or worse? (pressure, hot/cold, bowel movements, eating, etc)

_____

If there is pain, type of pain (sharp, stabbing, cramping, dull, achy, burning, hot/cold) _____

_____

Ears & Eyes:

Ears:

☐ Tinnitus ☐ Low-pitched ☐ High-pitched ☐ constant ☐ Comes and goes/Infrequent

☐ Deafness ☐ Ringing in the ears ☐ Pain Other:_____

Eyes:

☐ Glasses ☐ Night blindness ☐ Floaters ☐ Blurred vision ☐ Dry eyes ☐ Teary eyes

☐ Red Eyes ☐ Itchy ☐ Pain

Other:_____

Sleep:

Do you sleep well? ☐ Yes ☐ No Hours of sleep per night: _____

☐ Sleep through the night ☐ Insomnia ☐ Frequent dreams ☐ Nightmares

☐ Wake up frequently ☐ Difficulty falling asleep

Gynecology:

Is your period the same each month? ☐ Yes ☐ No Date of your last period _____

Number of days in cycle:_____ How many days is your period? _____ Contraception: _____

What colour is your flow (dark red, bright red, brown, etc)? _____

PMS Symptoms (cramps, pain etc.):_____

How heavy is your period? ☐ Normal ☐ Scanty ☐ Heavy ☐ Clots

Menopause: ☐ Yes ☐ No Age Menopause started: _____

Menopause Symptoms: _____

Any vaginal discharge? ☐ Yes ☐ No

If so, please describe colour, consistency, and odor_____

Pregnancy:

☐ Nausea ☐ Vomiting ☐ Lower abdominal pain Other:_____

Number of pregnancies: _____ Number of live births: _____

Postpartum:

☐ Bleeding ☐ Lochiorrhea ☐ Depression ☐ Fever Other:_____

Section D: Growth / Development & Current Health Habits

	Yes	No	Comments
Medications?	☐	☐	_____
Allergies	☐	☐	_____
Hospitalization/Surgery	☐	☐	_____
Do/Did you smoke?	☐	☐	_____
Do/Did you drink alcohol?	☐	☐	_____
Vaccinations?	☐	☐	_____
Are you physically active?	☐	☐	_____

Please Circle One:

Stress Level	High	Moderate	Low
Diet	Excellent	Good	Poor
Exercise	Excellent	Good	Poor
Sleep	Excellent	Good	Poor
General Health	Excellent	Good	Poor

Mark where the problem is and please describe what it feels like.

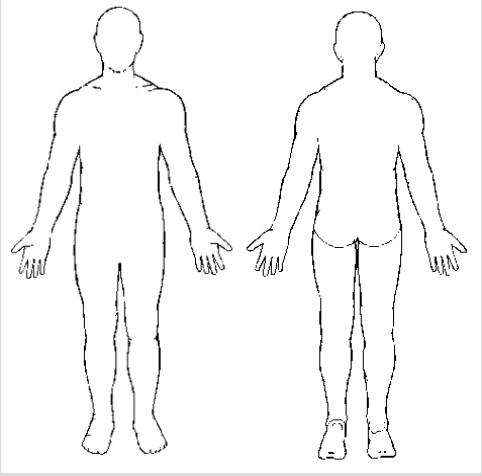
Sharp / Dull / Achy / Stabbing

_____

_____

_____

_____



Overall Energy:

☐ Shortness of breath ☐ Easily catch colds ☐ Low Energy

☐ Difficulty keeping eyes open in the daytime

☐ General weakness ☐ Feel worse after exercise

Section E:

Have you ever received acupuncture? ☐ Yes ☐ No

If yes, how long ago? _____ How often did you go? _____

Acupuncturist name: _____ Phone #: (_____)_____

Date of last visit: _____

Have you seen any of the following professionals?

☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ MD ☐ Other _____

If so, for what? _____

Reason for visit today? _____

How long have you had this condition? _____

What aggravates this? _____

What relieves this? _____

All the above information is true and accurate to the best of my knowledge.

_____ _____ _____

Printed Name **Signature** **Date**

INFINITE HEALING
CHIROPRACTIC & WELLNESS CENTRE