

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

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitalization/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/Did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/Did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaccinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you physically active?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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? _____

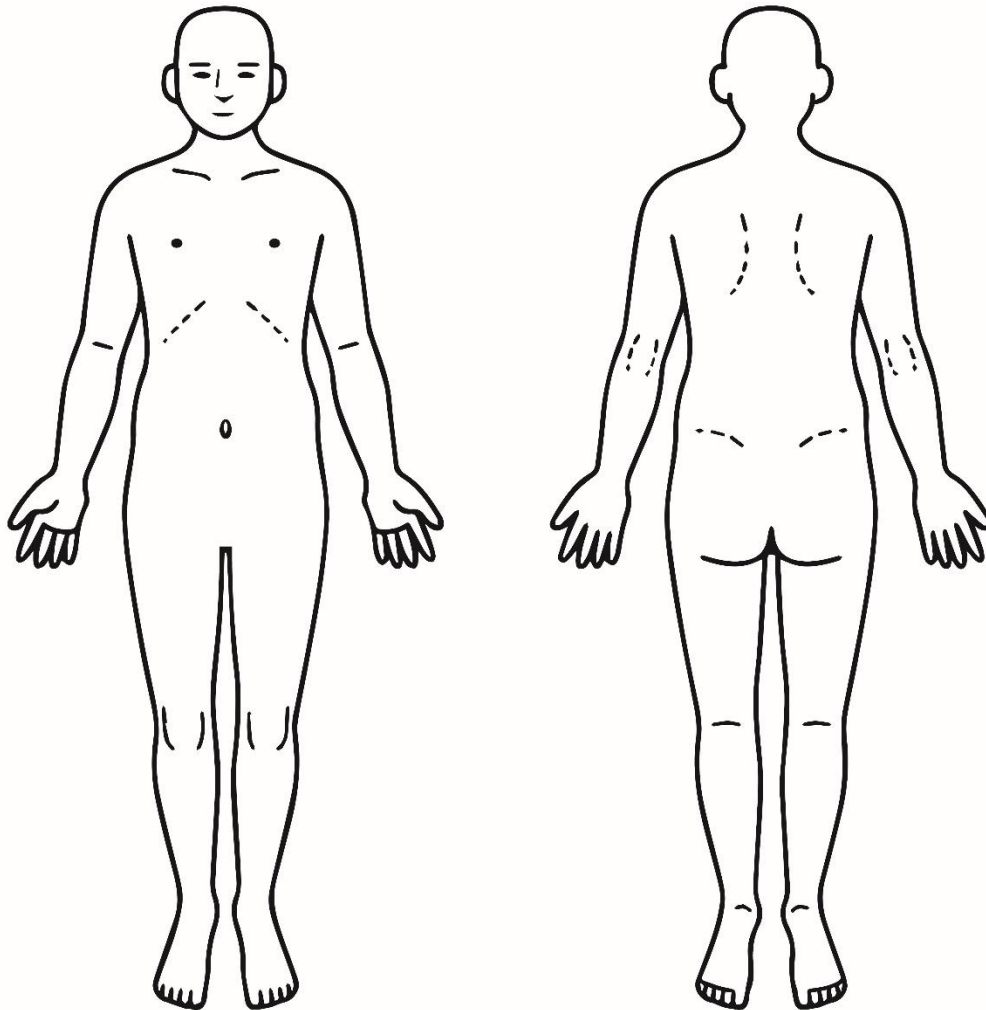
How often did you go? _____

Acupuncturist name: _____

Phone #: (_____) _____

Date of last visit: _____

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



Notes:

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