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Acupuncture Intake Form

Full Name: _____

Date of Birth: _____ **Age**: _____ **Gender**: F M

Mailing Address: _____

Home# _____ **Mobile#** _____ **Work#** _____

Email: _____

Emergency Contact:

Name: _____ **Relation**: _____

Home# _____ **Mobile#** _____ **Work#** _____

Medical Doctor:

Name: _____ **Phone**: _____

Address: _____ **Fax**: _____

Specialists and Other Current Health Practitioners:

_____

_____

Personal Health Number (Care Card) _____

How did you hear about *Active Back to Health Centre*?

_____

Have you had acupuncture before? Yes No

Would you like us to email you newsletters and special promotions? Yes No

Current Medical Information

What is the main reason for your visit today?

Current Health Concerns and/or Goals

Please list your concerns in order of importance, when the symptoms began and any treatments that you have tried.

1. _____Onset: _____

   Treatments: _____

2. _____Onset: _____

   Treatments: _____

3. _____Onset: _____

   Treatments: _____

4. _____Onset: _____

   Treatments: _____

General Info

Height: _____ Weight: _____ Weight 1 year ago: _____

Energy Level on a scale from 0-10: _____

When during the day is your energy the best? _____ worst? _____

What is your occupation? _____

Do you smoke? YES NO If yes, how many packs per day _____ For how long? _____

How many alcoholic drinks do you consume per week? None 1-4 5-7 7-10 10+

How many cups of caffeine do you drink per week? None 0-6 7-9 10-14 14+

Psychosocial

Please rate on a scale from 0-10 (10=best) how satisfied you are with the following areas of your life

Work/School _____
Financial Situation _____
Social Life/Friends _____
Spirituality _____

Relationship _____
Sexual Life _____
Family _____

ALLERGIES & SENSITIVITIES

Please list any known drug, environmental or food reactions that you have experienced and the reaction that occurred.

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

MEDICATIONS (Prescription drugs and over-the-counter preparations)

Please list all medications that you are currently taking, and any other information you can provide.

Drug	Dose	Reason for Taking	Year Started

SUPPLEMENTS (vitamins, herbal medicines, homeopathic preparations)

Please list all supplements that you are currently taking, and any other information you can provide.

Supplement *(Including brand if known)*	Dose	Reason for taking *(Including who prescribed this to you)*	Year Started

Review of Symptoms

Please check all symptoms that you have experienced during the last 6 months

GENERAL
- ○ Weight gain
- ○ Weight loss
- ○ Heat/Cold Intolerance
- ○ Insomnia
- ○ Fatigue
- ○ Night sweats

HEAD, EYES, EARS, NOSE & THROAT
- ○ Headache
- ○ Migraine
- ○ Ear pain
- ○ Ringing in ears
- ○ Changes in hearing
- ○ Itching or watery eyes
- ○ Dry or red eyes
- ○ Eye pain
- ○ Changes in vision
- ○ Throat pain
- ○ Difficulty swallowing
- ○ Sinus infection/pain
- ○ Nasal congestion

CARDIOVASCULAR
- ○ Chest pain
- ○ Heart palpitations
- ○ High blood pressure
- ○ Easy bruising
- ○ Varicose veins
- ○ Swollen feet/ankles
- ○ Cold hands/feet

RESPIRATORY
- ○ Difficulty breathing
- ○ Exercise intolerance
- ○ Cough
- ○ Hoarseness of voice
- ○ Sleep apnea
- ○ Snoring
- ○ Asthma or wheezing

GASTROINTESTINAL
- ○ Bloating & Flatulence
- ○ Indigestion
- ○ Constipation
- ○ Diarrhea
- ○ Blood and/or mucous in stool
- ○ Pain during bowel movements
- ○ Belching
- ○ Acid reflux
- ○ Hemorrhoids
- ○ Anal fissures
- ○ Nausea

EATING & APPETITE
- ○ Difficulty gaining weight
- ○ Difficulty losing weight
- ○ Frequent dieting
- ○ Poor appetite
- ○ Always hungry
- ○ Emotional eating
- ○ Cravings
- ○ Binge eating
- ○ Anorexia or bulimia

PSYCHOLOGY & NERVOUS SYSTEM
- ○ Anxiety or panic attacks
- ○ Depression
- ○ Difficulty concentrating
- ○ Poor memory
- ○ Numbness or tingling
- ○ Difficulty with speech
- ○ Seizures
- ○ Trembling or tremor
- ○ Dizziness or vertigo
- ○ Fainting or feeling lightheaded
- ○ Loss of balance
- ○ Difficulty walking

MUSCULOSKELETAL
- ○ Joint pain, redness, or stiffness

Specify _____
- ○ Neck or back pain
- ○ Foot cramps or pain
- ○ Wrist or hand pain
- ○ Joint deformity
- ○ Muscle pain or cramps
- ○ Muscle weakness
- ○ Restless legs
- ○ Tendonitis
- ○ TMJ /Jaw pain

URINARY
- ○ Acute or Chronic UTI's
- ○ Incontinence or Dribbling
- ○ Pain or burning on urination
- ○ Frequent urination
- ○ Blood in urine

IMMUNE
- ○ Enlarged lymph nodes
- ○ Painful or tender lymph nodes
- ○ Frequent infections
- ○ Frequent colds or flu
- ○ Slow wound healing

SKIN & NAILS
- ○ Acne
- ○ Athlete's foot
- ○ Jock Itch
- ○ Dandruff
- ○ Dark circles under eyes
- ○ Profuse sweating
- ○ Rashes or hives
- ○ Dry or itchy skin
- ○ Bumps on the back of arms
- ○ Suspicious moles
- ○ Changes in pigment
- ○ Hair loss
- ○ Brittle or breaking nails
- ○ White spots or ridges on nail

MEN'S HEALTH

Please check all boxes that apply

- ○ Prostate enlargement
- ○ Change in libido
- ○ Hernia
- ○ Erectile dysfunction
- ○ Testicular mass or pain
- ○ Prostate or urinary infection
- ○ Urinary urgency, hesitancy or dribbling
- ○ Sexually transmitted infections
  Specify: _____

Date of most recent PSA test: _____ Normal/Abnormal?

Date of most recent Prostate Exam: _____ Normal/Abnormal?

WOMEN'S HEALTH

Please provide the numbers as they apply

- ○ Pregnancy _____
- ○ Currently Pregnant
- ○ Miscarriage _____
- ○ Caesarean _____
- ○ Abortion _____
- ○ Vaginal Delivery _____
- ○ Living Children _____
- ○ Gestational Diabetes _____
- ○ Postpartum Depression _____
- ○ Breast Feeding _____

Date of last PAP test _____ Normal/Abnormal?

Date of last Mammogram _____ Normal/Abnormal?

MENSTRUAL HISTORY

Age at first period _____
Length of period _____
Length of cycle _____ Irregular Y N
Date of last period _____

- ○ Blood Clots
- ○ Menstrual Cramping
- ○ Breast Tenderness
- ○ Mood Swings/Irritability
- ○ Water retention
- ○ Depression

GYNECOLOGICAL CONDITIONS

- ○ Endometriosis
- ○ PCOS (Ovarian cysts)
- ○ Uterine Fibroids
- ○ Pain with Intercourse
- ○ Bleeding between periods
- ○ Infertility
- ○ Low libido
- ○ Fibrocystic breasts
- ○ Sexually transmitted infections
  Specify _____
- ○ Cervical dysplasia
- ○ Menopause, since age _____
  - ○ Hot flashes
  - ○ Vaginal dryness
  - ○ Night sweats
  - ○ Mood swings
  - ○ Difficulty concentrating
  - ○ Depression
- ○ Perimenopause, since age _____
- ○ Use of Hormone replacement therapy

Informed Consent for Naturopathic Care & Acupuncture

- I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing including the collection of blood, urine and/or saliva may be required.

- I confirm that the information I have provided to *Active Back to Health Centre* is complete and inclusive of all health concerns including the possibility of pregnancy and use of all current medications, including over-the-counter drugs.

- I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms is not guaranteed. Health risks of some naturopathic treatments include, but are not limited to:
    - Temporary aggravation of pre-existing symptoms
    - Allergic reactions and other adverse effects to botanical medicines or supplements
    - Pain, fainting, bruising or injury from venipuncture, acupuncture or cupping treatments

- I have had the opportunity to discuss with the naturopath/acupuncturist and/or with other clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that results are not guaranteed.

- I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and am informed that, as with all health care, the practice of acupuncture poses slight risks for treatment, including but not limited to temporary soreness, bruising, nausea, fainting, bleeding, injury and shock. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

- I confirm that I have the ability to accept or reject the recommended treatment at my own free will.

- I understand that a record of my visits and medical history will be kept, that this record will be strictly confidential and will not be released to any persons without my written consent.

- I have read and understood the fee schedule and I acknowledge that these services are not covered by MSP and I am responsible for payment of goods and services in full at each visit.

- I understand that there is a cancellation fee for appointments missed without notice or cancelled with less than 24 hours notice. I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patient visits are kept on time.

- I understand that the doctors at *Active Back to Health Centre* reserve the right to determine which cases fall outside their scope of practice, in which case an appropriate referral will be recommended.

- I have read the above consent. I have also had an opportunity to ask questions about the consent and by signing below I agree to the points listed above. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

THANK-YOU for your time and thoughtful consideration when filling out these forms, they will help us in understanding your whole health picture and create a plan that is unique to you.