Acupuncture Confidential Patient Intake

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PERSONAL DETAILS

Dr Mr Mrs Ms Miss _____

Last Name | First Name | Initial(s)

Address | City | Province | Postal Code

( ) - | ( ) - | ( ) -

Home Phone No. | Work Phone No. | Moblie Phone No. | DOB (MM/DD/YY)

Gender (M/F) | Occupation | E-Mail Address

Who referred you? _____

HEALTH INFORMATION

( ) -

Name of Medical Doctor | Telephone No. | Address

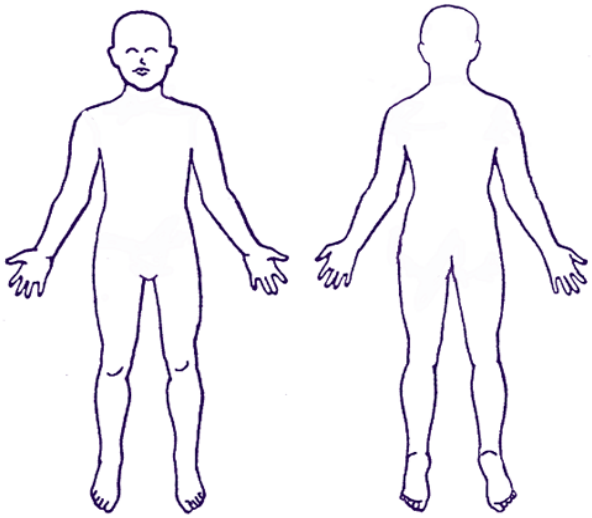
Date of Last Appointment | Date of Las Physical

EMERGENCY CONTACT

( ) - | ( ) -

Name | Relationship | Day Time Phone No. | Evening Phone No.

PAIN DIAGRAM



Please shade and code areas to indication location of pain or discomfort.

P - Pins & Needles
N - Numbness
S - Spasam
T - Tenderness
A - Aches
R - Radiations
B - Burning
X - Stabbing

PATIENT SYMPTONS

1. What is your principal problem or the one area of greatest concern? _____

_____

2. Do you think this concern has been getting worse? Yes / No

   If so, how quickly has it increased? Gradually / Suddenly

3. What do you think caused this problem? _____

_____

4. What makes if better? _____

_____

5. How offten do you experience this?

☐ 1-2 hours per day ☐ About 1/2 the day ☐ Most of the day ☐ Constantly

6. How does this concern affect your daily activities

☐ It does not affect them ☐ I have had to change how I do things

☐ I have had to stop doing some of them ☐ I am unable to perform most daily activities

7. Have you experienced this problem in the past Yes / No If so, when? _____

8. Which of the following treatments, if any, have you received for your complaint?

☐ Medication ☐ Physical Therapy ☐ Massage

☐ Chiropractic ☐ Acupuncture ☐ Other: _____

9. Which of the following treatmetns, if any, have benefitted you the most?

☐ Medication ☐ Physical Therapy ☐ Massage

☐ Chiropractic ☐ Acupuncture ☐ Other: _____

10. Secondary Compalint: _____

_____

11. What do you expect from your visit to the clinic? _____

_____

12. Do you have a pacemaker or any metal implants (e.g. screws)? Yes / No

If yes explain: _____

MEDICAL HISTORY / OTHER

1. Please list all medications you are currently taking (including vitamins and over the counger medications)

2. If female, when was your last period? _____

3. If female, are you pregnant? Yes / No / Unsure Are you trying to become pregnant? Yes / No

4. Below are several lists of diseases and conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Please check all that apply.

Diseases

☐ AIDS	☐ Anaemia	☐ Cancer	☐ Chicken Pox
☐ Diabetes	☐ Eczema	☐ Heart Disease	☐ Hepatitis A B C D
☐ Influenza	☐ Mental Disorder(s)	☐ Pneumonia	☐ Psoriasis
☐ Rheumatic Fever	☐ Smallpox	☐ Stronke / ITA	☐ Thyroid
☐ Arthritis	☐ Tuberculosis	☐ Other:	_____

Cardiovascular & Pulmonary System

☐ Chest Pain	☐ Heart Problems	☐ Varicose Veins	☐ Ankle/Calf Swelling
☐ Stroke	☐ Blood Pressure	☐ Lung Problems	☐ Congestion
☐ Irregular Heartbeat	☐ Shortness of Breath		

Gastrointestinal System

☐ Abnormal Appetite	☐ Gas / Bloating	☐ Upset Stomach	☐ Frequent Nausea
☐ Heartburn	☐ Diarrhea	☐ Excessive Thirst	☐ Ulcers
☐ Vomiting	☐ Weight Trouble	☐ Gall Bladder	☐ Constipation
☐ Abdominal Cramps	☐ Liver Problems	☐ Irriable Bowel	☐ Colitis
☐ Hemerrhoids	☐ Dark / Bloody Stool		

Genitourinary & Musculoskeletal System

☐ Bladder Trouble	☐ Vaginal Pain	☐ Breast Pain / Lumps	☐ Sexual Dysfunction
☐ Joint Pain / Stiffness	☐ Menstrual Cramps	☐ Vaginal Infection	☐ Menstrual Irreg'y
☐ Clicking Jaw	☐ Neck Pain	☐ Discoloured urine	☐ Painful Urination
☐ Walking Difficulties	☐ Pain b/w Shoulders	☐ Wrist / Hand Pain	☐ Arm Pain
☐ Difficultly Chewing	☐ Low Back Pain	☐ Prostate Problems	☐ General Stiffness

MEDICAL HISTORY / OTHER CONTINUED…

Nervous System / EENT

☐ Nervousness	☐ Numbness	☐ Fainting	☐ Paralysis
☐ Confusion	☐ Forgetfulness	☐ Dizziness	☐ Tingling
☐ Ears Ringing	☐ Ears Buzzing	☐ Stress	☐ Dental Problems
☐ Vertigo	☐ Hearing Difficulties	☐ Grinding Teeth	☐ Depression
☐ Vision Problems	☐ Sore Throat		

Allergies: _____

_____

Surgeries: _____

_____

Broken Bones: _____

_____