Harbour City Healers

Acupuncture Intake Form for Pregnancy Treatments

Information for your Acupuncturist
All information is strictly confidential.

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. If you have any questions or concerns, please do not hesitate to ask, thank you.

Patient Information Date: ________/________/________

Name: ____ Gender: ☐ Male ☐ Female
Address: ______________________________________ City: ______________________________
Province/Country: _________________________________ Postal code: __________________
Home Phone: (______)______________________ Cell Phone:(______)____________________
Age: ______ Date of Birth: ______/______/______ Place of Birth: ______________________
Guardian (if under 18): ____________________________ Height: ___'___" Weight: _____ lbs
Emergency Contact Name: _______________________ Phone:(______)_________________
E-mail: _______________________________ Receive e-mail communications? ☐ Yes ☐ No
Occupation: ____________________________ Retired: ☐ Yes ☐ No Year Retired ________
Extended Coverage: Provider/Card #'s: ____
MSP Premium Assistance (low income): ☐ Yes ☐ No Care Card #: _________________
Have you had Acupuncture before? ❑ Yes ❑ No Last treatment? __________________
How did you find us or who referred you? ____

Please list your **primary reason** for seeking care and any **major complaint(s)**

Major Complaints	Date of Onset
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________
4. ______________________________	______________________________
5. ______________________________	______________________________

To what extent do these problems affect your **daily activities** (work, sleep, eating, etc.)? ____
Other **physicians/therapists** seen for this condition(s): ___________________________
____
Have you been given a **Diagnosis** for the problem(s) ☐ Yes ☐ No. If yes, what is the **Diagnosis**? ____
List any **significant trauma** and **when** it **occurred** (accidents, falls, emotional etc):
____
Please list the name of any current **medications**, **vitamins** and **supplements** taken:
____
List any past or future **surgeries**: ____
Do you have any major **scars**: where? ____

Do you have any **allergies**? ❑ Yes ❑ No ___________________________________

Stress: ☐ None ☐ Moderate ☐ Severe ___________________________________

Do you **like** being in the: ☐ Wind ☐ Heat ☐ Cold ☐ Dryness ☐ Dampness

Do you **dislike** being in the: ☐ Wind ☐ Heat ☐ Cold ☐ Dryness ☐ Dampness

Signs & Symptoms: Check any you have had in the **past/present:**

☐ Autoimmune Disease	☐ Herpes	☐ Multiple Sclerosis
☐ Cancer/Tumor	☐ HIV/AIDS	☐ Paralysis
☐ Confusion	☐ Hypoglycemia	☐ Poor Concentration
☐ Diabetes	☐ Hyperthyroidism	☐ Poor Memory
☐ Dizziness	☐ Hypothyroidism	☐ Seizures
☐ Elevated Cholesterol	☐ Jaundice	☐ STDs
☐ Epilepsy	☐ Lack of Coordination	☐ Talk a little/lot
☐ Gonorrhea	☐ Loss of Balance	☐ Tremors
☐ Hepatitis ____________	☐ Meningitis	☐ Vertigo

Pregnancy Information: Due Date: ____________________

How many weeks pregnant? ________ Where do you plan to give birth? ____________

List the **names** and **contact information** of your Doctor/Midwife/Obstetrician:

____

____

Have you had any of the following **symptoms during** your **pregnancy**?

☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Constipation ☐ Urinary Tract Infections

☐ Varicose Veins ☐ Hemorrhoids ☐ Vulval Varicosities ☐ Fatigue ☐ Exhaustion

☐ Anemia ☐ Insomnia ☐ Anxiety ☐ Depression ☐ Vaginal Discharge/Itching

☐ Itching of Skin ☐ Sinusitis ☐ Pregnancy-Induced Hypertension ☐ Edema

# of Children: ________ # of Pregnancies: ________ Ages: ____________________

# of Miscarriages: ________ # of Abortions: ________ # of Premature Births: ________

Any complications with **past pregnancies**: ______________________________

Any health concerns related to **pregnancy**: ______________________________

Stress Test Results: ☐ Reactive ☐ Non-reactive Blood Pressure: ____________

General Information: Answer menstrual questions prior to pregnancy

Is your Menstrual Cycle Regular? ☐ Yes ☐ No Age of First Menstruation: ________

Average Duration of Menstrual Flow: ________ Average Duration of Cycle: ________

Date of Last Menstrual Period: ____________ Spotting Between Periods: ☐ Yes ☐ No

Bleeding: ☐ Light ☐ Normal ☐ Heavy Constitution: ☐ Watery ☐ Thin ☐ Thick

Color of Blood: ☐ Pale Red ☐ Bright Red ☐ Dark Red ☐ Brown ☐ Other: _________

Pain/Cramps: ☐ Yes ☐ No ☐ Before ☐ During ☐ After ☐ Last Hours ☐ Last Days

Clots: ☐ Yes ☐ No Size: ☐ Small ☐ Medium ☐ Large Color: ________________

Vaginal Discharge: ☐ Yes ☐ No Color: __________________ Smell: ☐ Yes ☐ No

PMS Symptoms: ____

☐ Decreased Libido ☐ Increased Libido ☐ Fertility Issues ☐ Postnatal Depression

☐ Endometriosis ☐ Polycystic Ovarian Syndrome ☐ Recurrent Yeast Infections

☐ Pain during Intercourse ☐ Vaginal Dryness ☐ Fibroids ☐ Breast Tenderness

Pain: Check the areas you have **pain/tension/tightness/discomfort**

☐ Neck ☐ Between Shoulders ☐ Ribs ☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Tailbone	☐ Shoulders ☐ Arms ☐ Elbows ☐ Hands ☐ Wrist ☐ Fingers ☐ Sciatica	☐ Hips ☐ Buttock ☐ Legs ☐ Knees ☐ Feet ☐ Ankles ☐ Toes	**Characterize** your **pain**: ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Electrical ☐ Numbness ☐ Sharp ☐ Stabbing ☐ Tingling ☐ Other: __________ ________________________________

Pain Level Scale:

1. None	2. Slight	3. Mild	4. Moderate	5. Discomforting
6. Distressing	7. Horrible	8. Severe	9. Excruciating	10. Disabling

What makes the **pain better**? ☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:
____

What makes the **pain worse**? ☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:
____

Is your **condition**: ☐ Constant ☐ Comes and goes ☐ Getting Worse ☐ Improving
Are you taking anything to control the pain? ☐ Yes ☐ No ____________________________
Have you had this **pain** in the **past**? ☐ Yes ☐ No _____________________________________

☐ Arthritis – OA/RA ☐ Tendonitis ☐ Bursitis ☐ Limited Range of Motion ☐ Stiff All Over ☐ Painful Muscles/Bones/Joints ☐ Loss of Grip ☐ Loss of feeling in the ☐ Hands ☐ Feet	☐ General Weakness ☐ Achy Body ☐ Body Heaviness ☐ Concussion ☐ Muscle Spasms/Twitch/Cramps ☐ Osteoporosis ☐ Hernia ☐ Gout

Headaches/Migraines: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: ____________________

Location:	Condition Aggravated by:	Character of Pain:
☐ Temples ☐ Left ☐ Right	☐ Cold ☐ Heat ☐ Fatigue	☐ Dull
☐ Occiput/Nape of Neck	☐ Emotional Tension	☐ Heavy Feeling
☐ Behind the Eyes	☐ Sexual Activity	☐ Pain 'Inside' the Head
☐ Forehead	☐ Eating	☐ Distending, Throbbing
☐ Side Of Head	☐ Other: _________________	☐ Boring, like a Nail in a small point
☐ Whole Head	☐ Improved by Rest	
☐ Top of Head/Vertex	☐ Improved by Eating	☐ Other: _________________

Energy: Low Time of Day: ____________________ High Time of Day: ____________________

☐ Energetic ☐ Chronic Tiredness/Fatigue ☐ Lack of Will Power ☐ Sudden Energy Drop	☐ Feel Worse after Exercise ☐ Feel Better after Exercise

Cardiovascular/Circulation:

☐ Chest Pain/Angina ☐ Tightness in Chest ☐ Feeling of Oppression ☐ Pressure in Chest ☐ Poor Circulation ☐ Difficulty Laying Flat ☐ Anemia ☐ Blood Disorder ☐ Stroke ☐ Cold Hands/Feet ☐ Cold Body Temperature ☐ Sweaty Hands/Feet ☐ Hot Body Temperature Edema of ☐ Hands ☐ Legs ☐ Abdomen ☐ Face	Blood Pressure ☐ Low ☐ High ☐ Palpitations ☐ Arrhythmia ☐ Easily Startled ☐ Fainting ☐ Arteriosclerosis ☐ Blood Clots ☐ Heart Disease ☐ Pacemaker ☐ Spider/Varicose Veins ☐ Swollen Hands ☐ Swollen Feet

Respiratory/Immune System:

☐ Asthma ☐ Shortness of Breath	☐ Frequent Colds/Flu ☐ Runny Nose
☐ Coughing up of Blood	☐ Chronic Cough ☐ Chills ☐ Fever ☐ Sneezing
☐ Coughing up of Phlegm	☐ Chest Congestion ☐ Wheezing ☐ Bronchitis
☐ Difficulty Breathing	☐ Pneumonia ☐ Mononucleosis ☐ Strep Throat
☐ In ☐ Out ☐ When Lying Down	☐ Tuberculosis ☐ Mumps ☐ Emphysema

Emotions that you Often Feel*:* ☐ Seeing a Therapist ☐ Abuse Survivor

☐ Alone	☐ Fits of Laughter	☐ Jealousy	☐ Panic Attacks
☐ Anger	☐ Forgetfulness	☐ Joy	☐ Pensiveness
☐ Anxiety	☐ Frustration	☐ Mania	☐ Restlessness
☐ Bipolar	☐ Grief	☐ Melancholy	☐ Sadness
☐ Bitterness	☐ Groaning	☐ Mood Swings	☐ Stress
☐ Crying	☐ Impulsive	☐ Nervousness	☐ Worry
☐ Depression	☐ Impatient	☐ Obsessive/Compulsive	☐ Other Emotions:
☐ Fearful	☐ Irritability	☐ Over Thinking	____________________

Eyes: ☐ Glasses ☐ Contacts

☐ Blurred Vision	☐ Dry Eyes ☐ Itchy Eyes	☐ Floaters/Seeing Spots
☐ Poor Night Vision	☐ Eye Pain ☐ Eye Strain	☐ Cataracts
☐ Near-Sighted	☐ Watery Eyes ☐ Gritty Eyes	☐ Glaucoma
☐ Far-Sighted	☐ Bloodshot Eyes ☐ Hot Eyes	☐ Photophobia

Ears & Nose:

☐ Poor Hearing ☐ Loss of Hearing	☐ Runny Nose ☐ Dry Nose ☐ Nosebleeds
☐ Earaches ☐ Plugged Ear	☐ Dull in Smell ☐ Loss of Smell
☐ High-Pitched Ringing in Ears	☐ Sinus Problems ☐ Sinus/Nasal Congestion
☐ Low-Pitched Ringing in Ears	☐ Hay Fever

Throat & Mouth:

☐ Sore Throat ☐ Dry Throat/Mouth	☐ Swollen Tongue ☐ Sticky Tongue
☐ Lump in Throat ☐ Hard to Swallow	☐ Loss of Taste ☐ Peculiar Taste
☐ Difficult Speech ☐ Hoarseness	☐ Sweet Taste ☐ Sour Taste
☐ TMJ ☐ Grinding Teeth ☐ Dental Problems	☐ Salty Taste ☐ Pungent Taste
☐ Excessive Saliva ☐ Excessive Phlegm	☐ Metallic Taste
☐ Canker Sores ☐ Sore Gums ☐ Tonsillitis	☐ Bitter Taste Constant
☐ Enlarged Glands ☐ Enlarged Thyroid	☐ Bitter taste in morning

Sleeping Habits: Average # of Hours/Night: ____________________

☐ Poor Sleep ☐ Heavy Sleep ☐ Restful Sleep	☐ Insomnia ☐ Somnolence
☐ Wakes Easily/Frequently ☐ Wake up Tired	☐ Difficulty Falling Asleep
☐ Sleeplessness due to Pain ☐ Sleep Apnea	☐ Wake Up Mid Sleep
☐ Dreams ☐ Nightmares ☐ Snoring	☐ Wake Up Early in Morning

Skin, Hair, Sweating, & Body:

☐ Dry Skin ☐ Itchy Skin ☐ Dandruff ☐ Early Graying of Hair ☐ Hair Loss ☐ Acne ☐ Pimples ☐ Changing Moles ☐ Eczema ☐ Psoriasis ☐ Easily Broken Bones ☐ Bleed or Bruise Easily	☐ Excessively Sweat ☐ Rarely Sweat ☐ Night Sweats ☐ Hot Flash ☐ Sweat Easily ☐ Rashes ☐ Hives ☐ Shingles ☐ Fungal Infections ☐ Ulcerations/Boils ☐ Other: please specify: _______________ ______________________________________

Gastrointestinal: Bowel Movements: Frequency/day: _________________

☐ Formed Stools
☐ Loose Stools
☐ Diarrhea
☐ IBS
☐ Constipation
☐ Laxative Use
☐ Black/White Stools
☐ Mucous in Stools
☐ Blood in Stools
☐ Odorous Stools
☐ Undigested Food in Stools
☐ Acid Reflux
☐ Heartburn
☐ Belching
☐ Hiccups
☐ Nausea
☐ Vomiting
☐ Vomiting of Blood
☐ Bad Breath
☐ Bloating
☐ Gas
☐ Indigestion
☐ Gurgling in Intestines
☐ Abdominal Pain
☐ Intestinal Pain/Cramps
☐ Rectal Pain
☐ Colitis
☐ Itchy/Burning Anus
☐ Hemorrhoids
☐ Stomach Ulcer
☐ Gall Stones
☐ Intestinal Worm/Parasite
☐ Prolapsed Organs

Genitourinary: Urination**:** Frequency/Day: _________________

☐ Clear in Color
☐ Pale Yellow
☐ Dark Yellow
☐ Cloudy/Turbid
☐ Blood in Urine
☐ Strong Odor
☐ Small Amount
☐ Large Amount
☐ Dribbling
☐ Very Frequent
☐ Urgent
☐ Night-Time Urination
☐ Incontinence/Lack of Control
☐ Retention of Urine
☐ Bedwetting
☐ Painful/Burning Urination
☐ Bladder Infections
☐ Kidney Stones/Disorder

Your Diet: Average # of Meals/Day: _________________

☐ Poor Appetite ☐ Excessive Hunger ☐ Abrupt Weight Gain ☐ Abrupt Weight Loss After Eating ☐ Fatigue ☐ Burning Sensation ☐ Absence of Thirst ☐ Excessive Thirst ☐ Crave Warm Drinks ☐ Crave Cold Drinks ☐ Thirst, Large Amounts of Cold Water ☐ Thirst, Small Sips ☐ Thirst, No Desire to Drink	Protein Intake ☐ Low ☐ High Dairy Intake ☐ Low ☐ High Sugar ☐ Low ☐ High Salty Foods ☐ Low ☐ High Bad Fats ☐ Low ☐ High Carbohydrates ☐ Low ☐ High ☐ Artificial Sweeteners

Your Lifestyle: Amount per Day/Week

Coffee ____________________ Tea ____________________ Water ____________________
Juice ____________________ Pop ____________________ Milk ____________________
Alcohol ______________________________ Cigarette ______________________________
Marijuana ________________________ Recreational Drugs ________________________
Regular Exercise ____

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Informed Consent for Acupuncture Treatment

By signing below, I hereby agree and consent to the performance of acupuncture and other TCM procedures. I understand that such procedures may include, but are not limited to acupuncture, manual and electrical stimulation, massage, fire cupping, gua-sha, acupressure, blood letting, infrared heat lamp, and nutritional counseling.

Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments. Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. I have been informed that in all acupuncture treatments only pre-sterilized, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

The Potential Benefits: Acupuncture may allow for the relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problems/ailments.

The Potential Risks: I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including slight pain or discomfort in the area of needle insertion, bruising, numbness or tingling, minor swelling, bleeding, infection, weakness, hematoma may occur at the side of insertion and may last a few days, fainting, dizziness and nausea. A sensation of light-headedness may occur after acupuncture treatment. Electro-acupuncture should not be used on patients who have a history of seizures, epilepsy, heart disease or strokes, or over a pacemaker. Blood letting procedure may cause pain, discomfort and bruising. Cupping can leave temporary bruised painful marks on the skin and there is also a small risk of burns or blisters. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I will immediately notify the acupuncturist if I experience any problems.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture is not a substitute for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I understand the clinical and administrative staff may review my patient records but all my records will be kept confidential and will not be released without my written consent. I understand that it is my responsibility to inform the practitioner of all current medications, herbs and supplements that I take.

In addition I will inform the practitioner of any **pace makers**, **artificial implants**, **addictions**, and **allergies** I have as they may affect the treatment plan. I state that I do not have the following conditions: **pregnancy**, **blood-borne diseases, local infections**, **bleeding disorders** or **taking anticoagulants**. If I have any of the above conditions, I have listed them here: ________________________

By voluntarily signing below, I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

________________________________ ________________________________

Printed Name of Patient Signature of Patient

____

Signature of Practitioner Date Signed: ________/________/________