Harbour City Healers

Acupuncture Intake Form for
Preparing for Delivery and Inducing Labour

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: ☐ Yes ☐ No Provider? _____
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 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 have any concerns with the following **areas/symptoms**?

☐ Pain, if so where? _____
☐ Headaches/Migraines ☐ Dizziness ☐ Memory/Concentration ☐ Cardiovascular
☐ High/Low Blood Pressure ☐ Respiratory ☐ Depression ☐ Anxiety ☐ Sleep
☐ Digestion ☐ Bowel Movements ☐ Urination ☐ Appetite/Thirst ☐ Libido
☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Mouth ☐ Sweating ☐ Skin ☐ Hair ☐ Body
☐ Other: _____
_____

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: _____
When did Engagement Occur? _____ Position of the Baby: _____
Do you have a Scheduled Induction Date? ❑ Yes ❑ No _____
Have you had any Contractions? ❑ Yes ❑ No If so, when? _____
Has your Water Broken? ❑ Yes ❑ No If so, when? _____
Has your Mucous Plug come out? ❑ Yes ❑ No If so, when? _____
Have you had a cervical sweep? ❑ Yes ❑ No If so, when? _____
Status of Cervix and Dilation: _____

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

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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: _____/_____/_____