Harbour City Healers

Acupuncture Intake Form

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
☐ Mental 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

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

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

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

Energy: Low Time of Day: _____ High Time of Day: _____

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

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: _____

Cardiovascular/Circulation:

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

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
☐ Frequent Dreams ☐ Nightmares ☐ Snoring	☐ Wake Up Early in Morning

Skin, Hair, Sweating, & Body:

☐ Dry Skin ☐ Itchy Skin ☐ Dandruff	☐ Lack of Perspiration ☐ Perspire Easily
☐ Early Graying of Hair ☐ Hair Loss	☐ Night Sweats ☐ Hot Flashes
☐ Acne ☐ Pimples ☐ Changing Moles	☐ Rashes ☐ Hives ☐ Shingles
☐ Eczema ☐ Psoriasis	☐ Fungal Infections ☐ Ulcerations/Boils
☐ Easily Broken Bones	☐ Other: please specify: _____
☐ Bleed or Bruise Easily	_____

Gastrointestinal: Bowel Movements: Frequency/day: _____

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

Genitourinary: Urination**:** Frequency/Day: _____

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

Your Diet: Average # of Meals/Day: _____

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

Your Lifestyle: Amount per Day/Week

Coffee _____ Tea _____ Water _____
Juice _____ Pop _____ Milk _____
Alcohol _____ Cigarette _____
Marijuana _____ Recreational Drugs _____
Regular Exercise _____

Women Only: ☐ Low Libido ☐ High Libido

☐ Infertility ☐ Postnatal Depression ☐ Endometriosis ☐ Fibroids ☐ Vaginal Dryness
☐ Polycystic Ovarian Syndrome ☐ Recurrent Yeast Infections ☐ Pain during Intercourse

If you are in menopause, please describe your past menstruation

Is there <u>any</u> possibility you are pregnant now? ☐ Yes ☐ No # of Children: _____
# of Pregnancies: _____ Any Complications: _____

Age of First Menses: _____	Is your Menstrual Cycle Regular? ☐ Yes ☐ No
First Day of Last Menses: _____	Spotting Between Periods: ☐ Yes ☐ No
Avg. Duration of Flow: _____	Bleeding: ☐ Light ☐ Normal ☐ Heavy
Avg. Duration of Cycle: _____	Constitution: ☐ Watery ☐ Thin ☐ Thick

Color of Blood: ☐ Pale Red ☐ Bright Red ☐ Dark Red ☐ Brown ☐ Other: _____
Pain/Cramps: ☐ Yes ☐ No ☐ Before ☐ During ☐ After Lasts ☐ Hours ☐ Days
Clots: ☐ Yes ☐ No Size: ☐ Small ☐ Medium ☐ Large Color: _____
Vaginal Discharge: ☐ Yes ☐ No Color: _____ Smell: ☐ Yes ☐ No
☐ Water Retention ☐ Bloating ☐ Headaches Before Period ☐ Headaches After Period ☐ Breast Tenderness PMS Symptoms: _____
Age of Menopause: _____ Symptoms: ☐ Depression ☐ Anxiety ☐ Crying Spells ☐ Spotting ☐ Hot Flashes ☐ Vaginal Dryness ☐ Other: _____

Men Only: ☐ Low Libido ☐ High Libido

☐ Infertility ☐ Low Sperm Count ☐ Impotence ☐ Erectile Dysfunction ☐ Discharge
☐ Premature Ejaculation ☐ Nocturnal Emissions ☐ Tired/Dizzy After Ejaculation
☐ Genital Pain ☐ Swollen Testicles ☐ Hot/Cold/Numb Genitals ☐ Prostate Problem

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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: _____/_____/_____