Acupuncture and Traditional Chinese Medicine **Confidential Health Intake Form**

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Date: _____
Case No.: _____

Welcome! Please take a moment to fill out the first page of this form and sign the consent form. All information will be held strictly confidential. Please let me know if you have any questions.

First Name: _____ Last Name:_____ Gender: M/F Age: _____
Address:_____City: _____ Prov.: _____ Postal Code: _____
Primary Phone#:_____Secondary Phone#:_____Email:_____
Date of Birth:_____Place of Birth:_____Years in Canada: _____
Living Arrangement: (Married/Live–in Partner/Single/Other)_____
Occupation:_____(Shift work/Regular Office Hours/Other) _____
How did you find us? _____Referred by: _____(Print/Online/Other)_____
What is the reason for your visit today?_____
_____
What are your treatment goals? _____
Primary Health Care Provider :_____ Phone number:_____
Address:_____City:_____ ____Postal Code:_____

Medical Health History

Personal Health History –Do you currently have or have you ever had (please check all that apply and include relevant dates and details):

- Allergies
- Dermatitis
- High/Low Blood Pressure
- Diabetes Type I/Type II
- Hepatitis A,B,C or D
- AIDS
- Cancer
- Thyroid Disease
- Venereal Disease
- Migraines
- Seizures
- Heart Disease
- Lung Disease
- Kidney Disease
- Hospitalizations
- Pregnancy

Please provide further detailed info here:

Family Health History – Does anyone in your immediate family have or have ever had (please check all that apply and provide further detail below):

- Allergies
- Diabetes
- Cancer

- Heart Disease
- High or Low Blood Pressure
- Seizures
- Stroke
- Other

Are you currently taking any prescription medications? Please List.

_____

_____

Are you taking: Supplements/ Vitamins/Herbs/Antacids/Pain Medications

Inquiry

Chief Concern:_____

History of present disease

Onset of present condition: _____

Diagnosis by family physician:_____

Location of pain and/or discomfort:

_____

_____

_____

_____

_____

Time of greatest discomfort:

_____

_____

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

Other treatment of therapies: _____

Musculoskeletal

Neck Pain	Muscle Pain	Knee Pain
Back Pain	Muscle Weakness	Foot/Ankle Pain
Hand/Wrist Pain	Shoulder Pain	Hip Pain

Any other joint or bone problems: _____

Pain

Dull	Stabbing	Distending_____
Lingering	Migrating	Contracting _____
Sharp	Burning	Aggravated by: Pressure Temp Climate_____
Heaviness	Numbness	Alleviated by: Pressure Temp Climate_____

Head, Eyes, Ears, Nose, Throat			
Dizziness	Migraines	Headaches	_____
Poor Vision	Blurred Vision	Night Blindness	_____
Spots(front of eyes)	Cataracts	Colour Blindness	_____
Eye Strain	Eye Pain	Eye Dryness	_____
Tinnitus	Poor Hearing	Earaches	_____
Sinus Problems	Nose Bleeds	Recurrent Sore Throat	_____
Grinding Teeth	Jaw Clicks	Facial Pain	_____
Sores on lips/tongue	Gum Problems	Teeth Problems	_____

Any other head or throat problems:_____

Cold and Heat			
Neither	Cold Back	Clammy hands/feet	_____
Cold/Hot	Chills	Fever	_____
Cold Hands/ Feet	Heat	Tidal fever	_____

Sweating			
Spontaneous	Night sweats	Hot flashes	_____
With exertion	No sweating	Local sweats	_____

Energy	1 2 3 4 5 6 7 8 9 10		
Fatigue	Fatigues easily	Sudden energy drop	_____
Dizziness	Excess energy	Drowsy	_____
Dyspnea/SOB	Fainting	Heavy feeling	_____

Cardiovascular		BP:_____/_____mmHg	
Dizziness	Low blood pres	High blood pressure	_____
Chest pain	Irreg. heart beat	Fainting	_____
Cold hands/feet	Swelling of hands	Swelling of feet	_____
Blood clots	Difficult breathing	Phlebitis	_____

Any other heart of blood vessel problems: _____

Respiratory

Cough | Coughing up blood | Asthma _____
Bronchitis | Pneumonia | Pain with Deep Inhalation _____
Difficulty Breathing (lying down) | Production of Phlegm (colour) _____
Any other lung problems _____

Sleep

Sound, restful | Not restful | Disturbed sleep _____
Heavy sleep | Insomnia | Dream-disturbed _____

Neuropsychological emotions

Poor memory | Areas of numbness | Loss of balance _____
Seizures | Concussion | Lack of coordination _____
Calm/relaxed | Anger | Grief _____
Depression | Irritability | Overthinking _____
Anxiety | Stress | Fear _____

Thirst

Thirst w/ desire | Likes cold drinks | Dry mouth _____
Thirsty w/ no desire | Likes hot drinks | Bitter Taste _____

Gastrointestinal / Appetite

0 1 2 3 4 5 (0=No Appetite, 5=Heavy)

Cravings | Nausea/vomiting | Heartburn | Food preferences:
Indigestion | Belching | Gas _____
Bloating | Bad breath | Abdominal pain/cramps _____
Diarrhea | Loose/watery | Explosive _____
Constipation | Dry, hard | Blood in stools _____
Foul smell | Rectal pain | Hemorrhoids _____
Any other GI problems _____

Genitourinary

Normal Urination | Frequent urination | Polyuria _____
Incontinence | Infrequent urination | Dysuria _____
Hematuria | Pain on urination | Scanty _____
Excess | Clear | Dark _____
Kidney stones | Impotence | Genital sores _____
Any other problems with genitourinary function: _____

Skin and Hair

Rashes | Ulceration | Hives _____
Itching | Eczema | Acne _____
Dandruff | Hair loss | Recent moles _____
Dry skin | Changes in hair / skin: _____
Any other hair or skin problems: _____

Lifestyle and Occupation

Regular exercise Weight gain Weight loss Shift work _____

Habitual consumption Cigarettes Caffeine Alcohol Other _____

Dietary considerations: _____

Occupational stress factors: _____

Gynecology

Age at first period: _____ _____Age at menopause: _____ Number of pregnancies:_____

Number of live births: _____Premature births: _____ Miscarriages/abortions: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last period: _____

Oral contraceptive use: _____ Type: _____ Duration of use: _____

Regular Irregular Amenorrhea _____

Menstrual clots Pale/dark menses Heavy/Light flow _____

Vaginal discharge Vaginal odour Breast lumps or swellings _____

PMS:_____

Other:_____
_____
_____
_____

Inspection, Auscultation and Olfaction

General Inspection: _____

Shen:

Bright Deficient Nervous Overall Impression:

Dull Excess Tics/Tremors _____

Complexion:

Sallow Flushed Dry skin _____

Dim Malar flush Dark Circles _____

Pale Red

Auscultation: _____

Weak voice Talks rapidly Rapid breathing Wheezing

Loud voice Talks slowly Sighs a lot Rattling in throat

Olfaction:_____

Tongue Diagnosis	Pulse Diagnosis

_____
_____
_____
_____
_____

Case Summary

_____
_____
_____
_____
_____
_____
_____
_____
_____

TCM Diagnosis

Disease: _____ Syndrome: _____

Treatment Principle: _____

Treatment Plan: _____

Acupuncture Prescription:

Additional Therapies:

Needles in:_____Time in:_____

#Needles out:_____Time out:_____

Notes:

Practitioner: _____ Date: _____

Fees $	Cash	Cheque	Other