ACUPUNCTURE AND MASSAGE CLINIC
PATIENT INTAKE FORM

NAME: _____ DATE OF BIRTH _____ AGE: _____

ADDRESS: _____ HEIGHT: _____ WEIGHT: _____ SEX: F M

_____ OCCUPATION: _____

_____ REFERRED BY: _____

PHONE # (H) _____ (W) _____ PHYSICIAN: _____

IN EMERGENCY NOTIFY: _____RELATIONSHIP: _____ PHONE: _____

MAIN PROBLEM: _____

WHEN DID THE PROBLEM BEGIN: _____ MEDICAL DIAGNOSIS: _____

WHAT OTHER TREATMENTS HAVE YOU TRIED? _____

HAVE YOU TRIED TCM BEFORE _____ ACUPUNCTURE _____ TUI NA _____ HERB _____ OTHER_____

ALLERGIES? (DRUGS, CHEMICALS, FOODS ETC.) _____

OCCUPATIONAL STRESS (CHEMICAL, PHYSICAL, PSYCHOLOGICAL) _____

MEDICATIONS: _____

SUPPLEMENTS: _____

ARE YOU ON A RESTRICTED DIET OR EXERCISE PROGRAM? _____

PLEASE DESCRIBE YOUR AVERAGE DIET: _____

HOW MANY MEALS DO YOU EAT A DAY? _____ DO YOU HAVE ANY CRAVINGS? _____

PLEASE CIRCLE THE PRODUCTS THAT ARE USED (CIGARETTES, ALCOHOL, DRUGS, COFFEE, TEA, SOFT DRINKS)

HOW OFTEN ARE THESE PRODUCT(S) USED A WEEK? _____

MEDICAL HISTORY

CANCER _____ HIV/AIDS _____ HEART DISEASE _____ DIABETES _____

THYROID DISEASE _____ VENEREAL DISEASE _____ HEPATITIS _____

BLEEDING DISORDERS _____ HIGH/LOW BLOOD PRESSURE _____

INDICATE AREAS OF PAIN OR DISTRESS:

GENERAL

- ❑ Any history of bleeding disorders
- ❑ Bleed or bruise easily
- ❑ Heart palpitations
- ❑ Shortness of breath
- ❑ Shortness of breath on exertion
- ❑ Recurrent infections
- ❑ Night sweats
- ❑ Sweating easily
- ❑ Edema
- ❑ Fatigue
- ❑ Sudden energy drop (time of day_____)
- ❑ Climate preference (warm/cold)
- ❑ Strong thirst (hot/cold)
- ❑ Thirst, no desire to drink
- ❑ Pain:where/type_____ _____ _____

Notes:

HEAD/EARS/EYES/NOSE/THROAT

- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness
- ❑ Ringing in ears
- ❑ Earache/Ear discharge
- ❑ Blurry vision
- ❑ Spots in front of eyes
- ❑ Eye dryness/pain
- ❑ Nasal discharge
- ❑ Nose bleeds
- ❑ Grinding teeth
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Sores on lips/mouth
- ❑ Other _____

Notes:

DIGESTION

- ❑ Heartburn
- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Anorexia
- ❑ Bulimia
- ❑ Abdominal pain/cramps
- ❑ Feeling of heaviness after eating
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Constipation
- ❑ Loose stools
- ❑ Undigested food in stools
- ❑ Mucus in stools
- ❑ Blood in stools
- ❑ Strong smelling stools
- ❑ Rectal pain
- ❑ Fissures
- ❑ Hemorrhoids
- ❑ Other _____

Notes:

GENITO-URINARY

- ❑ History of bladder/kidney infections
- ❑ Pain on urination
- ❑ Urgency with urination
- ❑ Frequent urination
- ❑ Blood in urination
- ❑ Decrease in urinary flow
- ❑ Unable to hold urine
- ❑ Incontinence at night
- ❑ Kidney stones
- ❑ Change in sexual drive
- ❑ Prostate problems
- ❑ Impotency
- ❑ Other

Do you wake up to urinate? Yes/No
How many times? _____

Notes:

SLEEP

- ❑ Hours of sleep per night____
- ❑ Quality of sleep_____
- ❑ Wake up at night
- ❑ Difficulty falling asleep
- ❑ Easily fall asleep
- ❑ Light sleeper
- ❑ Deep sleeper
- ❑ Wake up rested
- ❑ Nightmares
- ❑ Frequent dreams
- ❑ Other_____

Notes:

GYNECOLOGICAL

# of Pregnancies _____ # of births _____ # premature births _____ # of therapeutic abortions _____

Age of 1st menses_____
# of days between menses ____
Duration of menses _____

- ❑ Irregular periods
- ❑ Light periods
- ❑ Heavy period
- ❑ Clots
- ❑ Painful periods
- ❑ Unusual vaginal discharge
- ❑ Vaginal pain
- ❑ PMS
- ❑ Fibroids
- ❑ Breast lumps
- ❑ Endometriosis
- ❑ Infertility

Age of menopause_____
Date of last PAP_____
Other_____

Do you practice birth control? Yes No
Are you pregnant? Yes No
Are you trying to become pregnant? Yes No

Notes:

NEUROLOGICAL/BEHAVIOURAL

- ❑ Stroke
- ❑ Paralysis
- ❑ Poor balance
- ❑ Poor memory
- ❑ Difficulty concentrating
- ❑ Irritability
- ❑ Aggressive/bad temper
- ❑ Anxiety
- ❑ Depression
- ❑ Panic attacks
- ❑ Other_____

Notes:

TONGUE:

PULSE:

Signature _____ Date_____

In consideration to your fellow patient and therapists, 24 hours notice of cancellation must be given or a fee will be charged.