ACUPUNCTURE INTAKE FORM

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Name:	Date:

Major complaint / Health problem…

Description	*How long has this been an issue?*

Please list any medications or supplements you are currently taking…

Medication/Supplement	*Dose*	*For how long*	*Reason*

Please list any allergies to medication, herbs or food:

Please list any major surgeries, accidents or illnesses…

Description	*Date*

Women Only	**Women Only (Continued)**	**Men Only**
☐Abnormal pap smear	☐Low sexual energy	☐Genital pain
☐Bleed between periods	☐Yeast infections often	☐Impotence
☐Irregular periods	☐Urinary tract infections often	☐Lump in testicles
☐Heavy periods	☐Vaginal discharges	☐Penis discharge
☐< 25 day cycle	☐Menopausal	☐Nocturnal emission
☐>35 day cycle	☐Uterine prolapse	☐Low Sexual energy
☐Endometriosis	☐Facial hair	
☐Painful periods	☐Loss of head hair	
☐Premenstrual tension	☐May be pregnant	
☐Breast lumps	number of pregnancies?	
☐Contraceptives	complications during or after?	

Significant Illnesses (Please check all that apply)

□ Arthritis	□ Cancer/Tumour	□ Genetic Disease	□ Kidney Stones	□ Other:
□ Asthma	□ Diabetes	□ Heart Disease	□ Pacemaker	
□ Autoimmune	□ Depression	□ Hepatitis	□ Seizures	
□ AIDS/HIV	□ Gallstones	□ Hypertension	□ Thyroid disease	

Please check any symptoms you currently have or have had in the past year.

General
☐Chills
☐Low energy
☐Dizziness
☐Allergies
☐Fatigue
☐Fevers
☐Excess thirst
☐Insomnia
☐Nervousness
☐Numbness
☐Sweat spontaneously
☐Night sweating
☐Lack of sweating
☐Weight loss
☐Weight gain
☐Aversion to heat
☐Aversion to cold

Head & Neck
☐Blurred Vision
☐Heaviness in the head
☐Phlegm in throat
☐Cataract
☐Double Vision
☐Earache
☐Ear discharge
☐Eye pain/strain
☐Corrected vision
☐Nasal obstruction
☐Nasal discharge
☐Loss of sense of smell
☐Hearing loss
☐Hoarseness
☐Nosebleeds
☐Recurrent sore throat ☐ Red/inflamed eye
☐Ringing in the ears
☐Sinus problems
☐Sores on lips
☐Sores on tongue
☐Taste change
☐Teeth problems
☐Vision- see halos
☐Vision-see spots/floaters

Respiratory
☐Asthma
☐Hay fever
☐Persistent cough
☐Coughing blood
☐Shortness of breath
☐Recurrent bronchitis
☐Phlegm production
☐Difficulty inhaling
☐Difficulty exhaling

Cardiovascular
☐Chest pain
☐High blood pressure
☐Low blood pressure
☐Irregular heart beat
☐Poor circulation
☐Swelling of ankles
☐Varicose veins
☐Hypocondriac pain
☐Distention in chest or hypochondrium

Gastrointestinal
☐Abdominal pain
☐Bloating
☐Belching Gas
☐Constipation
☐Diarrhea/loose stool
☐Bloody stool
☐Black stool
☐Difficulty swallowing
☐Poor appetite
☐Heartburn/reflux
☐Hemorrhoids
☐Indigestion
☐Stomachache
☐Nausea
☐Vomiting
☐Vomiting blood

Weight
☐Underweight
☐Normal for height
☐Overweight
☐Very overweight

Diet/Lifestyle
☐Vegetarian
☐Healthy diet
☐Crave fried food
☐Crave red meat
☐Crave sweets
☐Crave salty food
☐Drink alcohol
☐Drink coffee
☐Smoke cigarettes
☐Use drugs
☐Take melatonin
☐Take Steroids
☐Exercise regularly
☐Exercise excessively

Musculoskeletal
Pain, weakness, numbness in:
☐Arms
☐Feet
☐Hands
☐Joints
☐Legs
☐Hips
☐Neck
☐Shoulders
☐Pain all over
☐Cold limbs
☐Knee problems
☐Low back pain
☐All over weakness
☐Lack of strength
☐Broken bones

Neurologic
☐Fainting
☐Convulsions
☐Handwriting change
☐Paralysis
☐Stroke
☐Seizures
☐Tremor
☐Recent clumsiness
☐Drowsiness
☐Vertigo

Skin
☐Thick skin
☐Thin skin
☐Broken blood vessels
☐Blood not clotting
☐Bruise easily
☐Discoloration
☐Dark circles around eyes
☐Bags under eyes
☐Lumps in groin
☐Lumps underarm
☐Dry skin
☐Acne
☐Brittle nails
☐Premature gray hair
☐Dry brittle hair
☐Hair falling out

Emotional
☐Insomnia
☐Irritability
☐Often feel angry
☐Troubling dreams
☐Cry uncontrollably
☐Feel sad a lot
☐Forgetful
☐Mind not clear
☐Anxiety
☐Much fear
☐Unrestrained joy
☐Terrors
☐Difficulty expressing

Genitourinary
☐Dilute urine
☐Dark urine
☐Blood in urine
☐Cloudy urine
☐Burning sensation
☐Scanty urine
☐Profuse urine
☐Frequent urination
☐Poor bladder control
☐Urgency to urinate

Waiver

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Allison Trent DTCM, RAc is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status. I agree to immediately inform the doctor if I experience any pain or discomfort during my treatment. I assume all risks and responsibilities for myself and release Adjust Your Health Calgary, its directors, and the independent practitioner consulted, from responsibility from any injury or liability that may occur as a result of this session.

I hereby request and consent to the performance of acupuncture care and other procedures related to acupuncture if necessary. This includes needling, moxibustion, cupping, guasha, electro-acupuncture, and other techniques within the scope of practice of the registered acupuncturist named below, in accordance with the Alberta Acupuncture Regulation.

I have had the opportunity to discuss the nature and purpose of acupuncture care and other procedures or alternative care with the registered acupuncturist named below. I understand that results are not guaranteed. I further understand and I am informed that, as in all health care, in the practice of acupuncture and related procedures, even though needles are pre-sterilized and disposable, there are some slight risks to treatment. These include but are not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection, and shock. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of procedures which the acupuncturist feels at the time, based on facts known then, are in my best interest.

I have read the above consent, I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Client (please print)	*Signature of Client*
Name of Registered Acupuncturist	*Signature of Registered Acupuncturist*
Date	