Active Health Chiropractic & Wellness Centre

Acupuncture Intake Form

Personal Information

Patient Name:_____

Age:_____ Birth Date:____/____/____ Gender:_____

Address:_____

City:_____Province:____Postal Code: _____

Telephone (Mobile):_____

Email Address:_____

Occupation: _____

Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____Phone:_____

HEALTH HISTORY: ***(Please list your health concerns and complaints in order of importance)***
1.
2.
3.
4.
5.

Do you have a contagious disease (ex. hepatitis, tuberculosis, flu) at this time? ☐ **Yes** ☐ **No**
If yes, please specify:

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No

Are you allergic to any medications, herbs, foods? ☐ Yes ☐ No
Medications:
Herbs:
Foods:
Other:

Are you taking medications for any of the following conditions*? (Check if applicable)*

		Name of Medication			**Name of Medication**
Heart/ Blood Pressure	☐		Laxatives	☐	
Steroids/ Tranquilizers	☐		Antacids (Stomach)	☐	

Pain Relievers	☐		Thyroid Medication	☐	
Antibiotics	☐		Hormone Replacement	☐	

Please list any medications, herbs or vitamins you are currently taking:
Medications:
Herbs:
Vitamins:
Other:

Please check boxes that are relevant to you pertaining to the following body system:

Cardiovascular System

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Fainting
- ❑ Lightheadedness
- ❑ Orthostatic Hypotension
- ❑ Chest Pain
- ❑ Slow Heartbeats
- ❑ Fast Heartbeats
- ❑ Irregular Heartbeats
- ❑ Diabetes
- ❑ Phlebitis
- ❑ Palpitations
- ❑ Heart Attack
- ❑ Angina

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

- ❑ Acne
- ❑ Ulcerations
- ❑ Fungal Infections
- ❑ Premature grey
- ❑ Alopecia
- ❑ Brittle hair
- ❑ Dry Skin
- ❑ Shingles
- ❑ Sore throat

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching
- ❑ Hiccup
- ❑ Ulcerative Colitis
- ❑ IBS
- ❑ Enteritis
- ❑ Itchy Anus
- ❑ Burning Anus
- ❑ Stomach Cramps
- ❑ Gastritis
- ❑ Gurgling Sounds

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Gynecology (Women)

- _____ Age of Menses
- _____ Duration of Menses
- _____ Date of Last Menses
- _____ # of Pregnancies
- _____ # of Births
- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

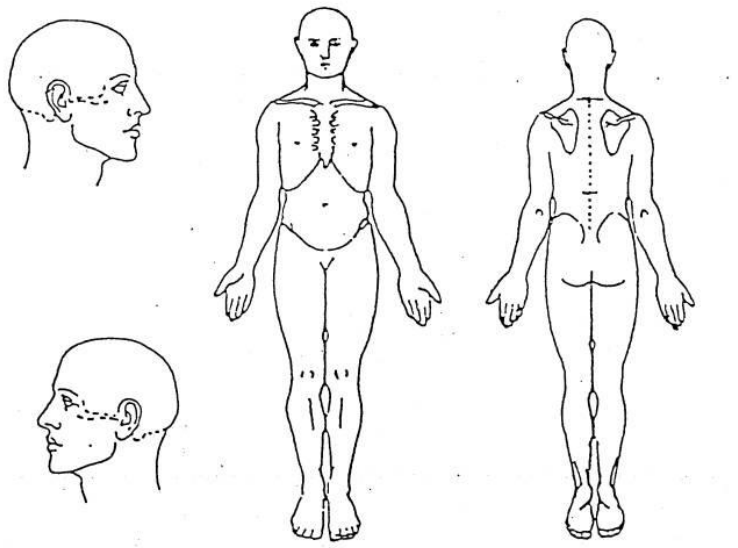
Men Only (check if applicable)

- ❑ Testicular Pain
- ❑ Impotence
- ❑ Erectile Dysfunction
- ❑ STI
- ❑ Prostate Problem
- ❑ Low Sperm Count

Musculoskeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Worse with Activity
- ❑ Worse with Weather

Please indicate any painful or distressed areas:



Describe any concerns you have regarding your comfort and safety during an acupuncture treatment such as: needle phobia, bleeding disorders (ex.haemophilia), pacemaker, medication pump, blood pressure, infections, compromised skin (ex. cuts, lesions, burns).