THRIVE
Chiropractic & Wellness Centre

Acupuncture Intake

Date: _____/_____/_____ (MM/DD/YY)
First Name: _____ Last Name:_____
DOB: _____/_____/_____ (MM/DD/YY) E-mail: _____
Preferred Phone #: _____ Other Phone: _____
Address: _____ Guardian: _____
_____
_____
Family Doctor: _____
Name of Referring Professional: _____
Emergency Contact: _____
(emergency contact phone #):_____
How did you hear about us?: _____
What is the reason for your visit?
_____ Pain management/Sports injury _____ General Wellness _____ Fertility

Do you have any of the following conditions?

____ High Blood Pressure
____ Fainting Spells
____ Hepatitis B or C
____ Diabetes Type 1
____ Pace Maker
____ Bleeding Disorder
____ Epilepsy
____ HIV/AIDS
____ Diabetes Type 2
____ None of the above

Please list all of your current medication and/or supplements:
_____
_____
_____

Please list any allergies to medication/food/environment:
_____
_____
_____

If you have recently had surgery, been in an accident or been diagnosed with a serious illness, please list the details below:
_____
_____
_____

What is your main concern?
_____
_____

Energy:

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Poor Moderate Excellent

____ Chronic fatigue ____ Mental fatigue ____ Heavy limbs
____ Easily winded ____ Unmotivated ____ Weakness
____ Spontaneous sweating

Sleep:

____ Difficulty falling asleep ____ Difficulty staying asleep ____ Insomnia
____ Busy mind at night ____ Pain at night ____ Sweating at night
____ Nightmares ____ Dreaming ____ Wake early
____ Tired after eating

Appetite:

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Low Normal Excessive

____ Abdominal Distention ____ Nausea / Vomiting after eating ____ Pain after eating
____ Preference for hot / cold food ____ Fullness after eating ____ Bloating
____ Bitter taste in the mouth ____ Acid Reflux ____ Regurgitation
____ Food allergies (please list): _____

Cravings:
____ Spicy ____ Salty ____ Sweet ____ Greasy ____ Bitter ____ Mild Flavours

Digestion:

Do you have regular bowel movements? YES / NO
How many bowel movements do you have a day? _____
____ Indigestion ____ Constipation ____ Diarrhea
____ Strong odour ____ Loose Stool ____ Abdominal Pain
____ Alternating constipation/diarrhea ____ Blood or Mucous in stool ____ Hemorrhoids
____ Undigested food in stool ____ Dry Stool ____ Urgency

Thirst:

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Low Normal Excessive

How much water do you drink a day? _____
Preference for HOT / COLD / ROOM TEMP
____ Dry Mouth ____ Bad Breath ____ No Thirst

Urination:

How often to you urinate? _____ X per day
____ Pain with urination ____ Urinary retention ____ Incontinence
____ Cloudy Urine ____ Bubbles in urine ____ Blood in urine
____ Urination at night ____ Frequent urination ____ Frequent UTI's

Pain:

Do you suffer from any of the following conditions?

_____ Chronic headaches/Migraines _____ TMJ _____ Low back pain
_____ Fibromyalgia _____ Fever _____ Cold/Flu
_____ Muscle tension _____ Arthritis
Other: _____

What conditions make your symptoms BETTER?
_____ Heat _____ Cold _____ Rest _____ Movement _____ Pressure
_____ Standing _____ Sitting
What conditions make your symptoms WORSE?
_____ Heat _____ Cold _____ Rest _____ Movement _____ Pressure
_____ Standing _____ Sitting _____ Weather changes

Emotion:

Do you have a history of mental illness? YES / NO
Do you suffer from any the the following?
_____ Depression _____ Anxiety/Fear _____ Irritability
_____ Anger _____ Constant worry _____ Sadness/Grief
_____ Other (please list): _____
Notes (if any):_____
_____
_____

Sexual Health (if applicable):

Sexual desire:

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Low Normal Excessive

For men:
_____ Erectile dysfunction/Impotence _____ Premature ejaculation

For women:
_____ Irregular cycles _____ Profuse vaginal discharge _____ Painful periods
_____ Heavy periods _____ Endometriosis _____ PCOS
_____ Fibroids/Polyps _____ Miscarriage / Stillbirth _____ Menopause
_____ Postpartum depression _____ No Periods _____ Pelvic pain
_____ Vulvar pain _____ Infertility

Is there a chance that you are pregnant? YES / NO
Do you have children? YES / NO If yes, how many? _____
Did you have problems during pregnancy/childbirth? _____
_____
_____

Please Continue To Consent Form

Consent Form

Potential risks of acupuncture can include bruising, slight discomfort at the sight of needle insertion, infection, weakness, numbness, nausea, fainting, and possible

aggravation of problematic systems existing prior to acupuncture. Unusual risks include nerve damage or organ puncture.

Cupping and guasha therapy can result in the discolouration of the skin (called petechiae) and resolves in about 3-5 days.

Herbal medicine is a supplemental plant/animal mineral source that is traditionally considered safe in the practice of Oriental medicine. Rare side effects of herbal medicine include digestive upset, nausea, headache, rash, hives, spontaneous miscarriage, and tingling of the tongue.

By signing this, I _____, certify that the
(PLEASE PRINT)
above medical information is correct to my knowledge. I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring health care professional as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand the risks associated with acupuncture, cupping, guasha, and herbal medicine. I have been given the opportunity to ask questions and/or voice concerns before my treatment protocol begins.

_____
(PATIENT SIGNATURE)

_____
(DATE)

_____
(PRACTITIONER SIGNATURE)

_____
(DATE)

We understand circumstances arise, however, please note a fee of 50% of the scheduled acupuncture fee will be applied for multiple missed or cancelled appointments without 24 hours notice.

_____
Initial