AIRDRIE ACUPUNCTURE

centre for pain, fertility & holistic health

ACUPUNCTURE INTAKE FORM

Warm greetings and welcome to our office. Traditional Chinese Medicine views all aspects of the individual's constitution to address your current symptoms. Although some of the material in this intake may not pertain to the condition of concern in today's visit, we ask you to fill this form out to your best ability.

Is this your first acupuncture experience (√)? ___ Yes

Name: _____ Date of Birth: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Work/ Home Phone: _____ Cell: _____

Email: _____

Emergency Contact Information

Name: _____ Phone: _____

Name: _____ Phone: _____

We are pleased to confirm your appointments through email. If you require a reminder phone call, please advise reception when booking your appointment.

Email (please print clearly): _____

ACUPUNCTURE INTAKE FORM

Please describe the main reason(s) for your visit today:

_____

_____

_____

Is your main concern getting (√) __worse __better __remains the same __comes and goes

Are you currently being treated by another health care professional or practitioner? _____

What therapies have you used for this condition? _____

Have they been effective? _____

Have you been recently diagnosed with a chronic condition? _____

Are you seeking treatment as a result of a motor vehicle accident (MVA)? _____
If so, please describe the date and injuries sustained:_____
_____

Are you involved in a lawsuit or any legal action for the MVA? _____

Are you seeking treatment for a work related injury? _____

Are you engaged in a Worker Compensation Board (WCB) claim? _____

LIFESTYLE HISTORY

Do you exercise: _____ How often? _____

List your physical activities: _____

What is your occupation: _____

What are your stress levels like? (√) __extreme __high __moderate __minimal __off and on

In what ways does your body cope with stress? (ie. tension headaches, digestive issues)
_____

What are your energy levels like? (√) __good __fair __low __exhausted

Do you have problems sleeping? (√) __no __difficulty falling asleep
__difficulty staying asleep __occasional insomnia

HEALTH HISTORY

Please check (√) the following medical requests that have been completed in the past year:

__blood work Any concerns? _____
__Xray Any concerns? _____
__MRI Any concerns? _____
__Ultrasound Any concerns? _____
__CT scan Any concerns? _____
__angiogram Any concerns? _____

Have you ever had a major illness, chronic condition, or disease? _____(Y/N)
If yes, please describe: _____

Please list any surgeries or hospitalizations:

Date:	Reason:
_____	_____
_____	_____
_____	_____

Please list medications taken over the last year:

Name:	Dosage:	How long:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all supplements you are currently taking:

Name:	Dosage:	How long:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

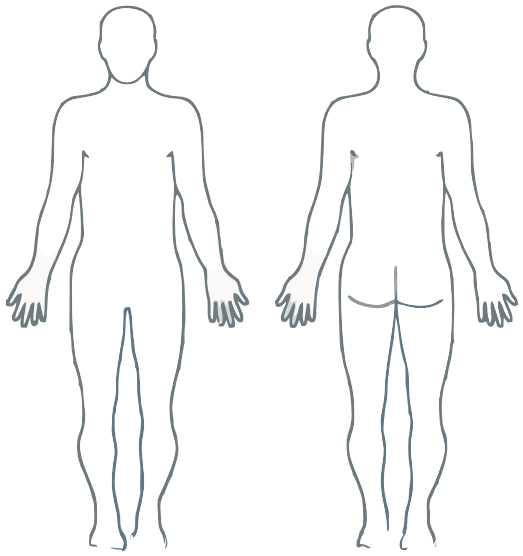
Do you have any allergies? _____

Please check the following that apply to you (√):
Do you smoke? __ How many per day? ___
Do you use pain killers? __ How often? _____
Do you consume caffeine? __ How often? _____
Do you consume alcohol? __ How often? _____
Do you use recreational drugs? __ What kind? _____ How often? _____

Do you have symptoms of pain or stiffness in the following areas (√):

__ Ankles
__ Elbows
__ Fingers
__ Hips
__ Knees
__ Lower back
__ Mid back
__ Neck
__ Sacroiliac joints
__ Shoulders
__ Upper back
__ Feet

Please indicate areas of pain or discomfort on the following figures:



FAMILY HISTORY

	Living	Age	General health	Age of Death	Cause
Mother:	_____	____	_____	_____	_____
Father:	_____	____	_____	_____	_____

Please note if Mother (M), Father (F), or grandparents (GP) has or had any of the following;

__ Alcoholism
__ Allergies
__ Anemia
__ Arthritis
__ Asthma
__ Bleeding disorder
__ Bi Polar
__ Cancer/Tumor
__ Mental Disorder
__ Colitis
__ Congenital Heart
__ Diabetes
__ Epilepsy
__ Hay Fever
__ Heart Disease
__ Heart Disease
__High Blood Pressure
__ Kidney Disease
__ Leukemia
__ Migraines
__ Nervous Breakdown
__ Obesity
__ Rheumatic Fever
__ Rheumatism
__ Schizophrenia
__ Ulcers
__ Stroke
__ Suicide
__ Thyroid
__ TB

Please check any condition that you have currently (c) or have had in the past (p);

__Alcoholism
__Allergies
__ Anemia
__ Angina Pectoris
__ Arthritis
__ Asthma
__ Back Pain
__ Bladder Disease
__ Bleeding Disorder
__ Bruise Easily
__ Cancer
__ Chest Pain
__ Cold Hands/Feet
__ Constipation
__ Depression
__ Diabetes
__ Disturbed Sleep
__ Dizziness
__ Dry Skin
__ Eczema
__ Edema
__ Emphysema
__ Epilepsy
__ Eye Infections
__ Forgetfulness
__ Gallstones
__ Grinding Teeth
__ Gum or Teeth Problems
__ Hay Fever
__ Hearing Loss
__ Heart Attack
__ Heart Disease
__ Hemophilia
__ Hepatitis
__ High Blood Pressure
__ HIV/AIDS
__ Hives or Rashes
__ Insomnia
__ Irritable Bowel Syndrome
__ Kidney Disease
__ Kidney Stones
__ Leukemia
__ Liver Disease
__ Loose Bowel
__ Low Blood Pressure
__ Malaria
__ Migraines
__ Nervous Breakdown
__ Neuralgia/Neuritis
__ Night Sweats
__ Osteoporosis
__ Palpitations
__ Perspiration
__ Pneumonia
__ Reduced Sexual Drive
__ Rheumatic Fever
__ Rheumatism
__ Ringing in the ears
__ Sciatica
__ Sexually Transmitted Disease
__ Sores in the Mouth
__ Stomach Ulcers
__ Stroke
__ Sudden Drops in Energy
__ Sudden Weight Loss/Gain
__ Tension/Anxiety
__ Thyroid Condition
__ Tuberculosis
__ Vision Problems
__ Other (please specify) _____

DIGESTIVE HEALTH

How is your appetite? __ good __poor __ never satisfied

Any issues with digestive function? Please check the following conditions that pertain to you.

__ Stomach Pains
__ Heart Burn
__ Indigestion
__ Bloating
__ Tiredness after meals
__ Cramping
__ Nausea
__ Hypoglycemia
Other: _____

What are your bowel movements like (√):

__ Regular
__ Irregular
__ Painful
__ Formed
__ Loose
__ Diarrhea

Do you suffer from constipation? Y/N ___
Do you have hemorrhoids? Y/N ____
Do you have blood or mucous in the stool? Y/N ___

Any issues with urination (√)?

__ Frequent
__ Oil Separation
__ Blood
__ Urgency
__ Dribbling
__ Painful
__ Cloudy Urine
__ Chronic Urinary Tract Infection

WOMAN HEALTH AND REPRODUCTIVE FUNCTION

Are you pregnant (Y/N)? ____ If so, how far along? _____

Is there a chance you may be pregnant (Y/N): _____

Are you currently trying to conceive (Y/N): ____

Have you had difficulties becoming pregnant (Y/N): ____

Have you experienced the loss of miscarriage (Y/N): ____ If yes, how many? _____

How many pregnancies have you had? _____

Do you have any children?

Name:	Age:	Sex:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENSTRUATION

Date of the first day of your last period: _____

Is your period regular (Y/N)? ____ What is the interval between periods? _____

How many days of menstrual flow do you have? _____

Please describe your menstrual flow:

	Color	Heavy/Light Flow	Pain/Cramping	Clots present
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				

WOMAN'S HEALTH CONTINUED

Do you have spotting (√): __ before your period __ after you period __ mid-cycle

Do you have clear signs of ovulation (ie. cervical mucous, temp. increase)? _____

Do you experience any premenstrual symptoms (√)?

__ Breast tenderness	__ Cramping	__ Depression
__ Headaches/migraines	__ Water retention	__ Mood swings
__ Fatigue	__ Loss of appetite	

Are you currently using birth control (Y/N)? __ If so, what kind? _____

Have you used birth control in the past (Y/N)? ___ When did you stop? _____

Date of your last Pap test: _____

Date of last breast examination: _____

How is your libido (√)? __ Good __ Low __ Very poor

How often do you engage in intercourse (√): __ Daily __Weekly __ Monthly __ Not at all

MENOPAUSE

Are you experiencing any of the following(√)?

__ Hot flashes or daytime sweats	__ Anxiety	__ Vaginal Dryness
__ Night sweats	__ Depression	__ Low libido
__Difficulty with concentration or memory	__ Weight gain	

Are you still menstruating (Y/N)? _____ At what age did menstruation stop? _____

Are you currently taking Hormone Replacement Therapy (Y/N)? ____

Please describe any other symptoms, conditions, or information you feel may be of importance in understanding your constitution or present state:

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ACUPUNCTURE CONSENT FORM

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including moxabustion, cupping, electro-acupuncture, Chinese herbals and other techniques within the scope of acupuncture. These procedures may be performed by Dr. Katie Li-Broussard and/or Dr. Jonna McQuade.

I have had the opportunity to discuss with the registered acupuncturist and/or with other office personnel the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that in the practice of acupuncture, as in all health care, there are some slight risks to treatment, although all needles are pre-steralized and disposable. These risks 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 of the risks and complications and I wish to rely on the acupuncturist to exercise judgement during the course of the procedures which the acupuncturist feels at the time, based on the facts then known, are in my best interest.

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

_____ _____

Patient's Name (Please Print) Date

_____ _____

Patient's Signature Witness