



# AIRDRIE ACUPUNCTURE

centre for pain, fertility & holistic health

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## 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

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Work/ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

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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:

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Is your main concern getting ( $\sqrt{\quad}$ )  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? ( $\sqrt{\quad}$ )  extreme  high  moderate  minimal  off and on

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

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What are your energy levels like? ( $\sqrt{\quad}$ )  good  fair  low  exhausted

Do you have problems sleeping? ( $\sqrt{\quad}$ )  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:

<input type="checkbox"/> blood work	Any concerns?	_____
<input type="checkbox"/> Xray	Any concerns?	_____
<input type="checkbox"/> MRI	Any concerns?	_____
<input type="checkbox"/> Ultrasound	Any concerns?	_____
<input type="checkbox"/> CT scan	Any concerns?	_____
<input type="checkbox"/> 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? \_\_\_\_\_

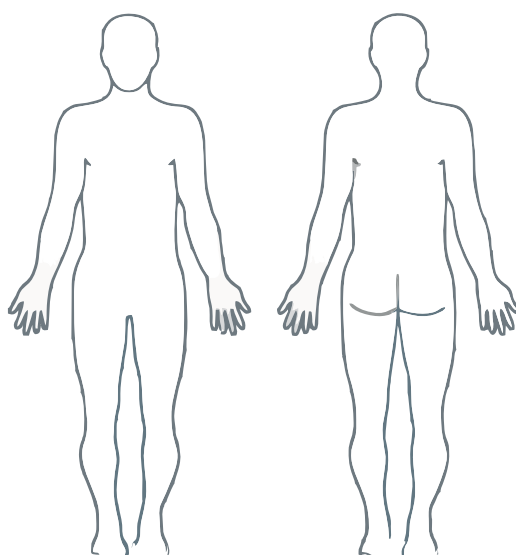
Please check the following that apply to you (√):

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 (✓):

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Ankles     | <input type="checkbox"/> Mid back          |
| <input type="checkbox"/> Elbows     | <input type="checkbox"/> Neck              |
| <input type="checkbox"/> Fingers    | <input type="checkbox"/> Sacroiliac joints |
| <input type="checkbox"/> Hips       | <input type="checkbox"/> Shoulders         |
| <input type="checkbox"/> Knees      | <input type="checkbox"/> Upper back        |
| <input type="checkbox"/> Lower back | <input type="checkbox"/> 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;

- |  |  |  |                                  |
|--|--|--|----------------------------------|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Ulcers  |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Congenital Heart    | <input type="checkbox"/> Leukemia          | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Obesity           | <input type="checkbox"/> TB      |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rheumatic Fever   |                                  |
| <input type="checkbox"/> Bi Polar          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rheumatism        |                                  |
| <input type="checkbox"/> Cancer/Tumor      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Schizophrenia     |                                  |
| <input type="checkbox"/> Mental Disorder   |  |  |                                  |

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

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

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach Pains | <input type="checkbox"/> Bloating              | <input type="checkbox"/> Nausea       |
| <input type="checkbox"/> Heart Burn    | <input type="checkbox"/> Tiredness after meals | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Indigestion   | <input type="checkbox"/> Cramping              | Other: _____                          |

What are your bowel movements like (✓):

- |                                    |                                   |  |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Regular   | <input type="checkbox"/> Formed   | Do you suffer from constipation? Y/N ____          |
| <input type="checkbox"/> Irregular | <input type="checkbox"/> Loose    | Do you have hemorrhoids? Y/N ____                  |
| <input type="checkbox"/> Painful   | <input type="checkbox"/> Diarrhea | Do you have blood or mucous in the stool? Y/N ____ |

Any issues with urination (✓)?

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Frequent       | <input type="checkbox"/> Urgency   | <input type="checkbox"/> Cloudy Urine                    |
| <input type="checkbox"/> Oil Separation | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Chronic Urinary Tract Infection |
| <input type="checkbox"/> Blood          | <input type="checkbox"/> Painful   |  |

MEN'S HEALTH AND REPRODUCTIVE FUNCTION:

Do you experience any of the following (✓):

- Achy Joints       Pain or pressure in the testes       Impotence
- Mood Changes       Difficult Urination       Decrease in libido
- Shortness of Breath       Dribbling       Trouble maintaining erection
- Dizziness/Lightheaded       Sores on genitals

Do you have high blood pressure (Y/N)?   
What was your last blood pressure reading? \_\_\_\_\_

How often do you engage in intercourse (✓):  Daily  Weekly  Monthly  Not at all

How is your libido (✓):  Good  Fair  Poor

Do you use performance enhancing drugs (Y/N)?   
If yes, what kind and how often? \_\_\_\_\_

Have you had a vasectomy (Y/N):

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

Do you have any children?

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

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-sterilized 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