Energy Health Clinic Acupuncture Intake & Medical History

To assist you with the best possible care, please fill out this form as accurately as you can. All information provided will be kept confidential.

Personal Information

Full Name:____________________________________

Date: _______________

Address:_____________________________________

City: ____

Province: _______ Postal Code: ________________

Phone (home): _______________________________

Phone (work/cell): ____________________________

Email:_______________________________________

Care Card Number:____________________________

Occupation:_________________ DOB: ___/___/___

Height______Weight:______Gender:_____________

Emergency contact: _____________________________

Emergency contact number:______________________

What forms of treatment/therapy do you currently or have you used?

____

Medical Doctor: ______________________________

Have you received acupuncture before? Y / N

Have you taken Chinese herbs before? Y / N

How did you hear about us?

____

Health History

Primary reason(s) for today's visit, in order of importance. Please include how long you've had it, how bad it is (1-10) what makes it better/worse, how it affects your sleep/work/relationships etc.:

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____

Medical Diagnoses (by an MD):____

Prescription drugs, over-the-counter drugs, supplements or herbs you are taking, and the condition you are taking them for:

____

____

Major accidents, illnesses, infections, birth traumas, surgeries, etc (include dental surgery and vaccinations):

____

____

Lifestyle/Social History:

Stress level (0-10):______Energy (0-10):_______ Smoker (or have ever been)? Y / N

Alcohol (drinks/week):_____Coffee (cups/day):_____ Past/present recreational drug user? (amounts/types):

Sugar (tbsp./day):____________________________ ____

Type and frequency of physical exercise:

____

Typical daily diet, and any food intolerances/sensitivities:

____

____

Family History (immediate family) of diabetes, heart disease, blood pressure disorder, neurological disorder, blood disorders, orthopaedic disorders, etc:

____

Please check any that apply:

☐ Blood Thinners
☐ Pacemaker
☐ Seizure Disorder
☐ Scheduled Surgeries
☐ Possibility of Pregnancy
☐ Hemophiliac/bleeding disorders
☐ Asthma
☐ Needle Sensitivity
☐ Stroke

Please Circle if Current Symptom, and Underline for past symptom:

General: weight loss, weight gain, sweats/night sweats, hot flashes, cold hands and feet, hot hands and feet, easily heated/chilled, fever and/or chills, fatigue/low energy, insomnia, psychoemotional disorder (anger, irritability, depression, anxiety, difficulty concentrating), easy motion sickness, no appetite in the morning, unusual sweating (palms, soles, elsewhere), unable to sweat, low energy in am, energetic in evening, spacey, scattered mind

Skin & Hair: eczema, acne, skin rashes, fungal infections/dandruff, dermatitis, psoriasis, warts, ridged nails

Musculoskeletal/effects of focal infections: joint pain, arthritis, skin disease, connective tissue or ligament disease, myofascial pain syndrome, fibromyalgia, tendinitis, pericarditis, constant slight fever, glomerulonephritis, plants fasciitis, scarlet fever, ear infections, streptococci infections, staphylococci infections, easily catch cold, sore throat, swollen glands, muscle cramps, paralysis, spinal curvature, numbness/tingling, back pain

ENT & Oral: blurred vision/visual changes, spots/floaters, eye pain, dry/itchy eyes, ringing ears, poor hearing, earaches/infections, sinus headaches, yellow mucus, stuffy nose, postnasal drip, dry mouth/throat, streptococci infections, sore throat, bleeding gums, tongue ulcers/cankers, gum pain, stomatitis (inflammation of the mouth), TMJ, cavities, toothaches without cavities

Respiratory: asthma, bronchitis, emphysema, cough, wheezing, pneumonia, lung abscess, frequent colds

Autoimmune & Inflammatory Conditions: Hashimoto’s thyroiditis, rheumatism, lupus, colitis, Crohn’s, alopecia, allergy, food allergy, atopic dermatitis, neurodermatitis, cellulitis, sinus allergy, vulvitis, lowered immunity

Heart/Vascular: palpitations, rapid heartbeat (>100 bpm), slow heartbeat (<60 bpm), irregular heartbeat, chest pains/tightness, shortness of breath, dizziness, cold hands/feet, Raynaud's, anemia, high/low blood pressure, red face, dizziness, swelling of ankles, high blood pressure, high cholesterol

GI: excessively hungry/thirsty, poor appetite/thirst, need to eat frequently, vomiting, acid reflux, ulcer, intestinal gas, hiccups/belching, bloating, abdominal/intestinal pain, bad breath diarrhea, constipation, black stools, blood/mucus in stool, itchy or burning anus, hemorrhoids, ileocecal valve spasm, peritonitis, pancreatitis, IBS, polyps, GI tumour

Genito-Urinary: pain or itching of genitalia, UTI's, painful urination, frequent/urgent urination, excessive or scanty urine, blood in urine, foamy urine, dribbling urination, incontinence, wake up to urinate, bedwetting, kidney stones

Hormonal Health: low/overactive thyroid, diabetes, hypoglycemia, other:

Male Reproductive Health (if applicable): impotence, infertility, seminal emissions, premature ejaculation, STD/STI's

Female Reproductive Health (if applicable): menstrual problems, cramping, heavy/light/irregular periods, vaginal discharge, PMS, emotional reactions, menopause symptoms, tubal ligation, infertility, endometriosis, polycystic ovaries, hysterectomy, high or low libido, breast tenderness, yeast infections

Age of first period: _____ Length of cycle:______Length of bleeding: _____ Currently pregnant? Y / N
Are you trying to become pregnant? Y / N

Please list any additional info:

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Treatment Consent & Cancellation Policy

I understand that I am responsible for attending my appointment and for paying a missed appointment fee if I do not give 24 hours notice to change or cancel my appointment. Many extended health plans have an allowance for Acupuncture treatments; the amount varies depending on your plan. It is also possible to obtain coverage through MSP, DND and DVA. I consent to communication with Energy Health Clinic via email for appointment reminders (and can unsubscribe at anytime).

I, ____ HEREBY CONSENT to treatment, namely acupuncture and/or related therapies to be performed by Alix Jean B.Sc., R.Ac I understand that one-time disposable needles are used in all treatment and that there may be a chance of bruising or slight soreness at some acupuncture points following treatment.

I will be consulted prior to the use of any acupoints that may be potentially dangerous or any treatment protocols that may cause any ill effects.

The information on this form is complete and true to the best of my knowledge, and I have read and understood the above consent for treatment.

____ ____
Signature **Date**

Welcome to Energy Health Clinic! We are delighted to have you as a new patient and we look forward to providing you with the highest quality of care.