Aculocus Clinic

Acupuncture Intake Form

Date: _____

Name: _____ Birthday: ___/___/___ Age: ____ Male □ Female □

(Last) (Middle) (First) (dd/ mm/yy)

Phone: (home)_____ Phone: (work/cell)_____

Address:

_____

(Street) (Apt/Suite #) (City) (Postal Code)

Email: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone #: _____

Reason for Visit

_____ Have you previously had: □ Acupuncture □ Chinese Medicine

Current health care providers

Family Physician: _____ Phone number: (___)_____

Western Medical diagnosis (if applicable): _____

Other medical treatment received: □ Fertility Clinic □ Physiotherapy □ Massage □

Naturopath □ Chiropractor □ Other _____

Health Overview

Please indicate with 'P' (past) 'C' (current) 'F' (family) if any of these conditions apply:

Heart condition Stroke High /Blood Pressure Low Blood Pressure

Diabetes Deep Vein Thrombosis Neurological Spinal or head injury

Respiratory conditions

Kidney Disorder Cancer Hepatitis

HIV/AIDS Sprain/Strain/Fracture Osteoporosis Headaches/Migraines

Jaw Pain Arthritis Dizziness/Fainting Contagious Illness

Skin Condition Digestive Problems Hemophiliac Pacemaker

Lung Condition Epilepsy Possibility of Pregnancy Upcoming surgeries

On the figures below, please circle areas of concern/pain: Please list any prescription medication or over the counter drugs currently taking:

1. _____

2. _____

3. _____

4.. _____

List all herbal medicines or supplements currently taking.

1. _____

2. _____

3. _____

4.. _____

Sensations/pain characteristics (check all that apply):

Sharp □ Burning □ Moving □ Tingling □ Dull □

Severe □ Stabbing □ Shooting □ Throbbing □

Numbness □

What relieves the pain (ice, rest, activity, massage, heat…)?

_____

What aggravates the pain (weather, heat, cold, rest, activity…)?

_____

Please list any allergies (food, drugs, environmental, etc):

1. _____

2. _____

3. _____

4.. _____

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Lifestyle

How often do you consume:

Caffeine _____ Added salt _____

Pop _____ Artificial sweeteners _____ Sugar _____

Alcohol _____ Recreational drugs _____ Tobacco _____

Do you participate in the following physical activities? If so, please indicate how often:

□ Yoga □ Running □ Fitness Class □ Gym □ Biking

□ Swimming □ Walking □ Other

For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan

___ Irritability / frustration / impatient

___ Stress

___ Unfulfilled desires

___ Blurred vision / poor night vision

___ Headaches / Migraines

___ Feeling of lump in throat

___ Neck / shoulder tension

___ Sighing

___ PMS

___ Depression

___ Emotional eating

___ Visual problems / floaters

___ Red / Dry / Itchy eyes

___ Dizziness

___ Muscle twitching / spasm

___ Brittle nails

___ Sensation or pain under rib cage

___ Genital itching / pain / rashes

Xin

___ Palpitations

___ Insomnia / Sleep problems

___ Vivid dreams

___ Forgetful

___ Bitter taste in mouth

___ Chest pain / tightness

___ Restless / easily agitated

___ Lack of joy in life

___ Aversion to heat

___ Tongue / mouth ulcers / cankers

Shen

___ Frequent urination

___ Lack of Bladder control

___ Feel cold easily

___ Night sweats / hot flushing

___ High sex drive

___ Hearing problems

___ Fear

___ Bladder infection

___ Wake to urinate

___ Cold hands / feet

___ Low sex drive

___ Loss of head hair

___ Crave salty food

___ Poor long term memory

___ Ankle swelling

___ Tinnitus

Fei

___ Dry cough

___ Cough with Phlegm

___ Nasal discharge / drip

___ Sinus infection / congestion

___ Itchy / painful throat

___ Dry mouth / throat / nose

___ Skin rashes / hives

___ Snoring

___ Grief / sadness

___ Shortness of breath

___ Allergies / asthma

___ Weak immune system

___ Alternate fever / chills

Pi

___ Heaviness in the head / body

___ Fatigue / after eating

_ Morning difficulty getting up in

___ Water retention

___ Muscular tired / weak

___ Bruise easily, Unusual bleeding (stool, nose,

___ Bad breath

___ Poor appetite

___ Increased appetite

___ Crave sweets

___ Poor digestion

___ Nausea / vomiting

___ Bloating / gas

___ Hemorrhoids

___ Constipation

___ Loose stool

___ Alternate constipation / loose

___ Abdominal pain

___ Intestinal pain / cramping

___ Heartburn

___ Pensive / over-thinking

___ Overweight

___ Foggy mind

___ Yeast infection

___ Aversion to cold

___ Cold nose

___ Increased Thirst

___ Prefer Warm / Cold drinks

___ Sweat easily

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation?

Do you enjoy work?

How many hours per week do you work?

Is your job stressful?

What are your duties?

Are your bowel movements regular?

How many times per day/week?

Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention?

What color/shade of yellow is it?

Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken Antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

How did you hear about our clinic?

□ Phone book □ Walked by the clinic □ Clinic website

□ Print advertising □ Brochure □ Facebook □ Referral by: _____

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks.

Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

• Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;

• Minor bleeding or bruising can occur from acupuncture;

• In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment.

This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;

• Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

• Bruising (looks like a circular hickey) is a common side effect of cupping;

• The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

• If you have ever experienced a fit, faint, or other odd detached sensations;

• If you have a pacemaker or any other electrical implants;

• If you are pregnant;

• If you have a bleeding disorder;

• If you are taking anti-coagulants (blood thinners) or any other medication;

• If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Aculocus clinic , unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Aculocus clinic (also, Aculocus clinic will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored in hard copy format on Aculocus clinic premises. On occasion, Aculocus clinic may use client/patient information to conduct clinical studies to help us improve upon services provided.

_____ _____

Print name in full Signature

(Print name of representative if represented by another) (Signature of Representative)

_____

Date