



## **ACUPUNCTURE PATIENT INTAKE FORM**

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

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Tel. \_\_\_\_\_ Bus/Cell Tel. \_\_\_\_\_

E-Mail \_\_\_\_\_

Date of Birth (D/M/Y) \_\_\_\_\_ Age \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Tel. # \_\_\_\_\_

Do you have extended Health Benefits \_\_\_\_\_ Do they cover Acupuncture \_\_\_\_\_

Who referred you to our office \_\_\_\_\_

Reason for consulting our office:

\_\_\_\_\_

\_\_\_\_\_

Expectations: \_\_\_\_\_

### **Prior Acupuncture Care:**

Name of practitioner: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physiotherapist or Acupuncturist: \_\_\_\_\_ If so when: \_\_\_\_\_

Results Achieved: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

### **Medical Doctor:**

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

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

Date of last appointment: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

### **Medical Specialist:**

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

Specialty: \_\_\_\_\_ Date of last appointment: \_\_\_\_\_

### **Dentist:**

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

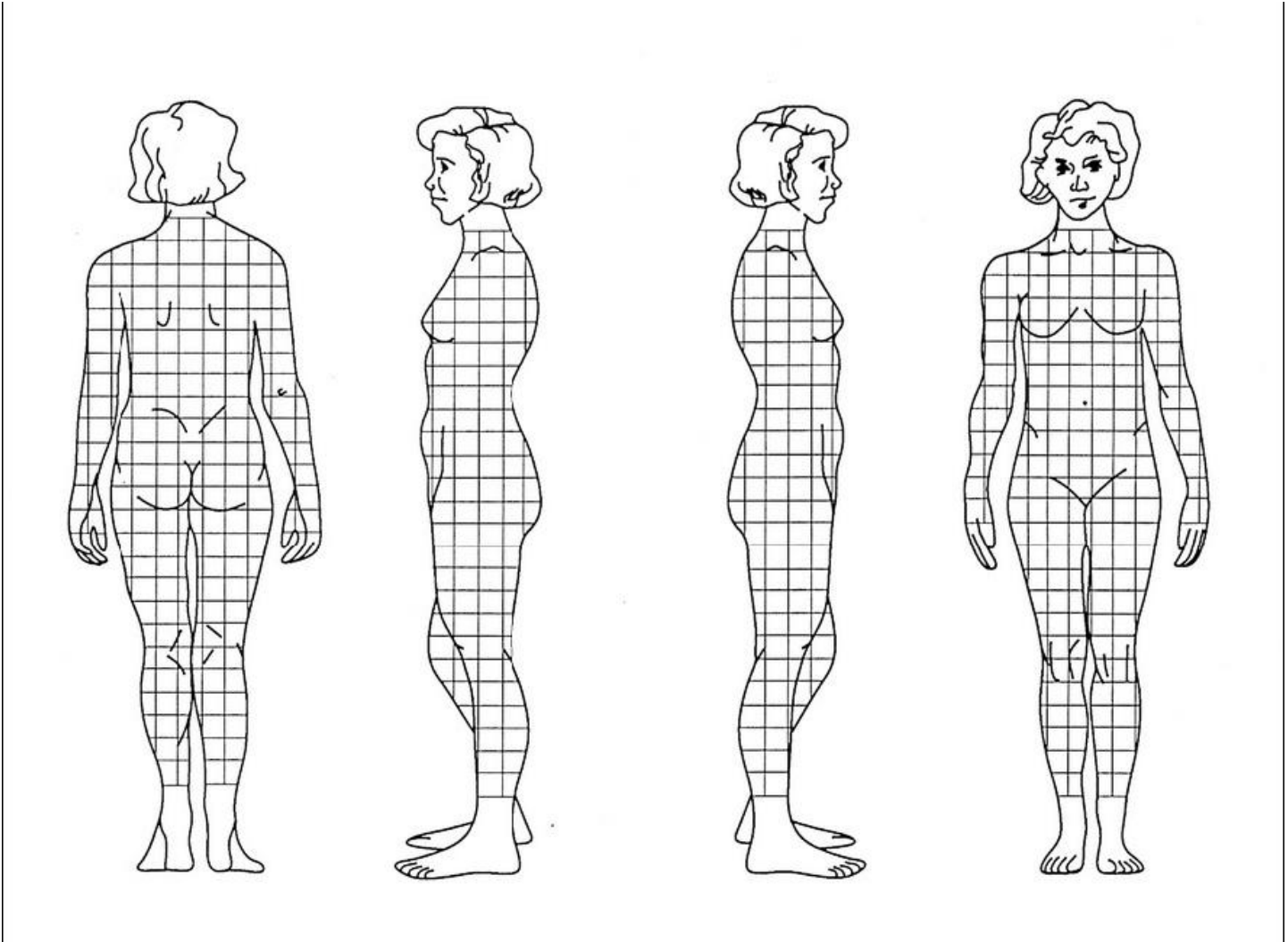
Location: \_\_\_\_\_ Date of last appointment: \_\_\_\_\_

List of past dental procedures: \_\_\_\_\_

\_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Sharp
- T** = Tingling (pins & Needles)
- C** = Cramping



Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social, and spiritual condition over the past one month. Use an X on the line to mark the point that summarizes your overall sense of well-being for the past month.

□-----□

Worst you have ever been

Best you have ever been

Please list current medications and the condition(s) they are treating:

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## BODY SYSTEM REVIEW

### Headache:

Location: \_\_\_\_\_ How often: \_\_\_\_\_ Type of Pain: \_\_\_\_\_

Dizziness: \_\_\_\_\_ Numbness/Tingling: \_\_\_\_\_

**Eyes:** Red: \_\_\_\_\_ Itchy: \_\_\_\_\_ Watery: \_\_\_\_\_ Blurry: \_\_\_\_\_ Floaters: \_\_\_\_\_

Night Vision: \_\_\_\_\_ Glasses: \_\_\_\_\_

**Ears:** Ringing: \_\_\_\_\_ Pitch: \_\_\_\_\_ Other: \_\_\_\_\_

**Gums:** Bleeding: \_\_\_\_\_ Other: \_\_\_\_\_

**Teeth:** \_\_\_\_\_

**Throat:** Swollen glands/Sore throat: \_\_\_\_\_

Shortness of Breath: \_\_\_\_\_

Notes: \_\_\_\_\_

## BODY TEMPERATURE & PERSPIRATION

General Body Temp: Hot: \_\_\_\_\_ Cold: \_\_\_\_\_ Where: \_\_\_\_\_

Chills: \_\_\_\_\_ Sense of Heat: \_\_\_\_\_

Hot Flashes: \_\_\_\_\_ Night sweats: \_\_\_\_\_ Spontaneous: \_\_\_\_\_

Notes: \_\_\_\_\_

## DIET & THIRST

What do you eat: \_\_\_\_\_

What do you NOT eat: \_\_\_\_\_

How does food affect you: Tired \_\_\_\_\_ Bloating \_\_\_\_\_ Gas \_\_\_\_\_ Burping \_\_\_\_\_ Pain \_\_\_\_\_

Other: \_\_\_\_\_

How is your appetite: \_\_\_\_\_ Cravings: \_\_\_\_\_

Eat 3 meals/day: Yes \_\_\_\_\_ No \_\_\_\_\_ Skip meals \_\_\_\_\_ Taste in Mouth: \_\_\_\_\_

Daily Liquid Consumption: \_\_\_\_\_ Cold or hot liquids: \_\_\_\_\_ Add Ice? Yes \_\_\_\_\_ No \_\_\_\_\_

Caffeine: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_

Notes: \_\_\_\_\_

## ELIMINATION

Urination: Output per day: \_\_\_\_\_ Color: \_\_\_\_\_ Blood: \_\_\_\_\_ Cloudy: \_\_\_\_\_

Urgent: \_\_\_\_\_ Burning: \_\_\_\_\_ Retention: \_\_\_\_\_ Scanty: \_\_\_\_\_ Dribbling: \_\_\_\_\_

Night time: \_\_\_\_\_ Times/Night: \_\_\_\_\_

Notes: \_\_\_\_\_

Stools: Frequency: \_\_\_\_\_ Hard: \_\_\_\_\_ Loose: \_\_\_\_\_ Formed: \_\_\_\_\_

Complete: Y\_\_\_ N\_\_\_ Constipation: \_\_\_\_\_ Diarrhea: \_\_\_\_\_ Alternating: \_\_\_\_\_

Difficulty: \_\_\_\_\_ Undigested Food: \_\_\_\_\_ Blood: \_\_\_\_\_ Mucus: \_\_\_\_\_

Notes: \_\_\_\_\_

## **SLEEP**

Hours/night: \_\_\_\_\_ Time to bed: \_\_\_\_\_ Time to wake: \_\_\_\_\_

Rested when wake up: \_\_\_\_\_ Trouble falling asleep: \_\_\_\_\_

Waking in the night: \_\_\_\_\_ Trouble going back to sleep: \_\_\_\_\_

Dreams: \_\_\_\_\_

Worries/Thoughts: \_\_\_\_\_ Palpitations: \_\_\_\_\_

Notes: \_\_\_\_\_

## **EMOTIONS**

At this time: \_\_\_\_\_

Mood swings \_\_\_\_\_ Anxiety \_\_\_\_\_ Depression \_\_\_\_\_ Irritability \_\_\_\_\_

History of abuse \_\_\_\_\_ Attempted suicide \_\_\_\_\_ Stress Level: \_\_\_\_\_

Notes: \_\_\_\_\_

## **FEMALE**

Pregnant?: Yes\_\_\_ No\_\_\_ Length of Cycle: \_\_\_\_\_ # Days Bleeding: \_\_\_\_\_

Pain: \_\_\_\_\_ When: \_\_\_\_\_ Clots: \_\_\_\_\_ Flow: \_\_\_\_\_

Color \_\_\_\_\_: \_\_\_\_\_ PMS: \_\_\_\_\_

Irritable: \_\_\_\_\_ Mood Swings: \_\_\_\_\_ Breasts Tender: \_\_\_\_\_

Cravings: \_\_\_\_\_ Fatigue: \_\_\_\_\_

Birth Control: \_\_\_\_\_ Pregnancies \_\_\_\_\_ Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Menarche Age: \_\_\_\_\_ Vaginal Discharge: \_\_\_\_\_ Yeast Infections: \_\_\_\_\_

Menopause: Age at Onset: \_\_\_\_\_ Hot Flashes: \_\_\_\_\_ Night Sweats: \_\_\_\_\_

Notes: \_\_\_\_\_

## **MALE**

Prostate: \_\_\_\_\_ Sexual function \_\_\_\_\_

Dysfunction: \_\_\_\_\_



**Dr Danielle Caruk, DTCM, RAc**

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**Chinese Medicine & Acupuncture Clinic**  
**Disclosure Statement & Informed Consent**

**Clinic Fee Schedule** (due at time of service) Prices include GST

**Adult first treatment \$100.00**

**Adult follow-up \$75.00**

**Insurance:** We do not bill insurance. We will provide you with a receipt for your insurance company upon request.

All appointments that are cancelled / rescheduled with less than 24 hours notice and appointments missed without notice will be charged a fee of \$50.00.

**Informed Consent**

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

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

Signature of Patient or Person authorized to consent Relationship or Authority of Representative