THE WELLNESS STUDIO
FAMILY CHIROPRACTIC & WELLNESS CARE

# Acupuncture Intake Form

Name: _____ Date of Birth (D/M/Y): _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____ Reminder Emails: Y / N

Home Telephone: _____ Bus / Cell: _____

Emergency Contact: _____ Ph. #: _____

Who referred you to the clinic / how did you hear about us

☐ Friend: _____ ☐ Internet ☐ Health Practitioner: _____

☐ Other: _____

Family Doctor

Name: _____ Telephone: _____

Date of last appointment: _____ Date of Last Physical: _____

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

_____

_____

_____

**Reason for Today's visit in order of importance:**

**1.** _____
**2.** _____
**3.** _____

Is it getting worse? ☐ Yes ☐ No

Does it affect your: ☐ Sleep ☐ Daily Activities ☐ Other: _____

What seemed to be the initial cause? _____

What makes it better? _____

What makes it worse? _____

Please list other current Treatments / modalities being utilized for this condition: _____

_____

**Prior Care:**

Physiotherapist or Acupuncturist: _____ If so, when? _____

Results Achieved: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Family Medical History**

Indicate if you or a close relative (parent, sibling) have any of the following:

| | You / Relative |
|---|---|
| Allergies | |
| Asthma | |
| Diabetes | |
| Kidney Disease | |
| Birth Defects | |
| Juvenile Arthritis | |
| Other | |

Surgeries (List year, reason & hospital):_____

_____

_____

Other Trauma or Hospitalizations (Car Accidents, falls, etc.):_____

_____

Are you currently on any prescribed medicine (prescriptions, over the counter, vitamins, herbs, homeopathic, etc)? ☐ Yes ☐ No If yes, what? _____

_____

Please list prescription medication within the last year: _____

_____

Please indicate if any apply with a P= Past C= Current F= Family

| | | | | | |
|---|---|---|---|---|---|
| | Headaches | | Heart Condition | | Spinal / Head injury |
| | Dizziness / Fainting | | Stroke | | Cancer |
| | Jaw Pain | | Kidney Disorder | | Hepatitis |
| | Arthritis | | Low / High Blood Pressure | | Shingles |
| | Skin Condition | | Diabetes | | AIDS |
| | Contagious Illness | | Deep Vein Thrombosis | | Sprain/ Strain/ Fracture |
| | Respiratory Disorder | | Neurological Condition | | Osteoporosis |

**Body System Review**

**Headache:** Location: _____ How Often: _____ Type of pain: _____
Dizziness: _____ Numbness/ Tingling: _____

**Eyes:** Red: _____ Itchy: _____ Water: _____ Blurry: _____ Floaters: _____ Night Vision: _____
Glasses / Contacts: _____

**Ears:** Ringing: _____ Pitch (high / low): _____ other: _____

**Gums:** Bleeding: _____ Other: _____

**Teeth:** Loose: _____ Clenching: _____ TMJ: _____

**Throat:** Swollen Glands / Sore Throat: _____

**Lungs:** Shortness of Breath: _____ Cough: _____ Sputum: _____

**Heart:** Palpitations: _____ Heaviness: _____ Burning: _____

**Notes:**

**Body Temperature & Perspiration**

General Body Temp: ☐Hot ☐Cold Where: _____

Chills: _____ Sense of Heat: _____ Hot Flashes: _____

Night Sweats: _____ Spontaneous: _____

Notes:

**Diet & Thirst** (please complete the sample menu according to an average day)

Morning - Snacks –

Noon - Beverage Types-

Evenings - Amount / type Beverage –

**Do you eat or drink the following (if so what and how often)**

Dairy _____

Frozen treats / drinks _____

Raw Vegetables _____

Raw Salads _____

Cold / Hot Drinks (preference?) _____

Are you Vegetarian? _____

**Cravings**

☐ Salty ☐ Sweet ☐ Sour ☐ Bitter ☐ Spicy

What do you NOT eat: _____

How does it affect you: ☐ Tired ☐ Bloating ☐ Gas ☐ Burping ☐ Pain Other: _____

Hunger: ☐ Frequently Hungry ☐ No Appetite ☐ Normal

**Liquid Consumption per day & amount:** Water_____ Caffeine: _____ Alcohol: _____

**Tobacco: Cigarettes or pack / day _____ Chew _____ Pipe _____ Cigars _____ E-cigarettes_____**

**How Many Years Smoking? _____**

**Caffeine per day:** ☐ None Coffee: _____ Tea: _____ Cola: _____

**Alcohol per day / week:** Beer: _____ Wine: _____ Liquor: _____

**Exercise**

☐ No Exercise

☐ Mild Exercise (active increase in heart rate more than 2 times a week, walk short distance, golf, climb stairs)

☐ Moderate Exercise (Less than 4x week for at least 30 minutes)

☐ Intensive Exercise (4 or more times a week for more than 30 minutes)

Please list activities and Duration: _____ _____

_____ _____

**Elimination**

**Urination**: Output = Input: _____ Colour: _____ Blood: _____ Cloudy: _____
Urgent: _____ Burning: _____ Retention: _____ Scanty: _____
Dribbling: _____ Night time: _____ Times / Night: _____
Notes:

**Stools:** Frequency / day_____ Hard: _____ Loose: _____ Formed: _____ Complete Y / N
Constipation: _____ Diarrhea: _____ Alternating: _____ Difficulty: _____
Undigested food in stool: _____ Blood: _____ Mucus: _____
Notes:

**Sleep**

Trouble fallings asleep: _____ Waking in the night: _____ Time waking: _____
Trouble falling back to sleep: _____ Dreams: _____ Worries /Thoughts: _____
Notes:

**Emotions (Please check off what you feel in a month)**

☐ Mood Swings ☐ Anxiety ☐ Depression ☐ Frustration ☐ Worry ☐ Irritability ☐ Sadness

Stress Level (between 1-10): _____

Notes: