Female

Purity Health & Wellness Inc.

Acupuncture Intake Form

Name: _____
LAST FIRST

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Confirmation: E-mail / Phone / Text

DOB (D/M/Y):_____/_____/_____ How do you identify: Male / Female

Emergency Contact:_____
NAME RELATIONSHIP PHONE

Occupation:_____ Employer:_____

Ins Company:_____ Referred by?_____

New Patient Intake Form

Please fill out the intake form to the best of your knowledge. You're more than welcome to add any additional information that may not be on the intake.

Have you had acupuncture before? Yes No

Have you consulted a physician/dentist about the condition that you are currently seeking treatment? Yes No

Main Concerns:
1. _____
2. _____
3. _____

Past Medical History:
1. _____
2. _____
3. _____

Family Medical History:
Mother's side: _____
Father's side: _____

Have you ever been hospitalized or had any operations? Please explain:
_____
_____
_____

Do you have any injuries or any past injuries? Please explain:

_____
_____
_____

Medications / Supplements / Vitamins - Please list any that you are currently taking and reason for use:

_____
_____
_____

Do you have any allergies? Please list and explain what the reaction to them is:

_____
_____
_____

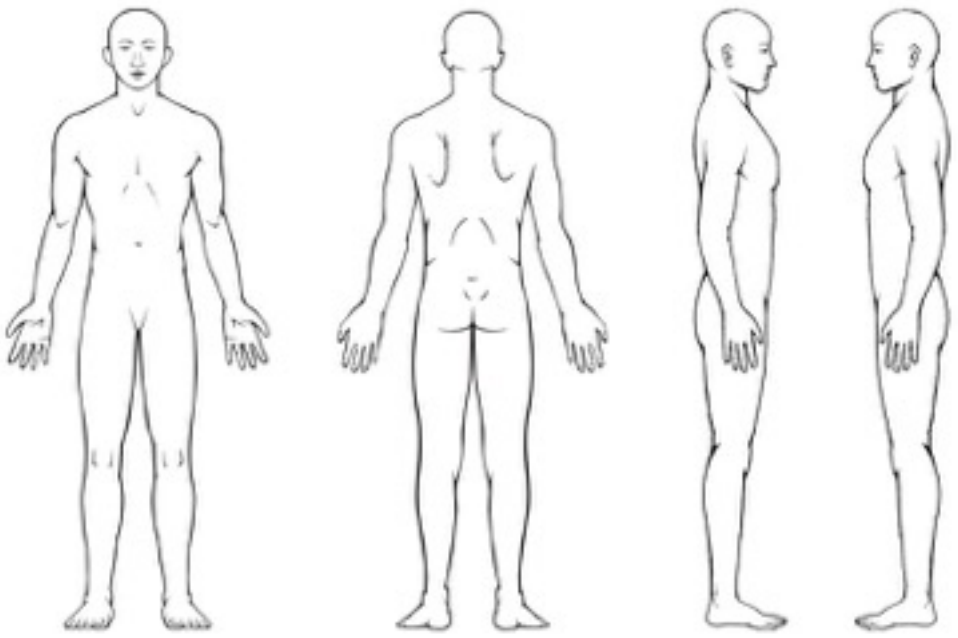
Pain:
Please clearly mark any areas of pain:
Key: **XXX** - Pain / **OOO** - Tingling / **NNN** - Numbness / **SSS** - Stabbing

Does anything make the pain worse?

_____

What helps alleviate this pain?

_____



Lifestyle:
Do you participate in any physical activities? Please describe:
_____
_____

What do you do to relax and alleviate stress:
_____
_____

What are the many causes of stress in your life?
_____
_____

Dietary Information:
Do you eat breakfast? Yes No
How much water do you drink each day? _____
How many servings of fruit and vegetables do you eat each day? _____
Alcohol:___ (# / week) Coffee/Tea: ___ (# / week) Pop: ___ (# / week) Tobacco: ___ (# / week)
How is your appetite? _____
Do you crave certain foods? _____
Do you feel thirsty often? _____
Any unusual tastes in the mouth? _____

Sleep:
How many hours of sleep do you get at night? _____
- ☐ Insomnia
- ☐ Nightmares
- ☐ Waking tired
- ☐ Waking frequently
- ☐ Dream disturbed sleep
- ☐ Problems staying asleep
- ☐ Problems falling asleep
- ☐ Other:_____

Heart:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pains
- ☐ Palpitations
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Slow heart beat
- ☐ Feel light headed
- ☐ Phlebitis
- ☐ Orthostatic hypotension
- ☐ Other:_____

Lungs:
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Chest oppression
- ☐ Asthma/wheezing
- ☐ Chronic Cough
- ☐ Dry cough
- ☐ Cough with phlegm
- ☐ Difficulty breathing when lying down
- ☐ Other:_____

Skin & Hair:
- ☐ Itchy skin
- ☐ Dry skin
- ☐ Oily skin
- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Shingles
- ☐ Acne
- ☐ Fungal infections
- ☐ Hair loss
- ☐ Brittle hair
- ☐ Premature greying
- ☐ Other:_____

Head, Eyes, Ears, Nose & Throat:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurred vision
- ☐ Eye strain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Floaters in eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Sore throat
- ☐ Dry mouth
- ☐ Clears throat often
- ☐ Tongue sores
- ☐ Gum disease
- ☐ Sore gums
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Problems with TMJ
- ☐ Grinding teeth
- ☐ Soft teeth
- ☐ Multiple cavities

Gastrointestinal:

# of bowel movements per day_____

- ☐ Constipation
- ☐ Diarrhea
- ☐ IBS
- ☐ Ulcerative colitis
- ☐ Colitis/enteritis
- ☐ Hard stools
- ☐ Loose stools
- ☐ Black stools
- ☐ Mucus in stools
- ☐ Blood in stools
- ☐ Vomiting
- ☐ Nausea
- ☐ Gas
- ☐ Bloating after meals
- ☐ Undigested food in stool
- ☐ Acid regurgitation
- ☐ Gastritis
- ☐ Stomach cramps
- ☐ Intestinal cramps
- ☐ Hemorrhoids
- ☐ Other:_____

Genito-Urinary:

- ☐ Frequent urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Burning urination
- ☐ Cloudy urination
- ☐ Urination at night
- ☐ Retention of urine
- ☐ Incontinence
- ☐ Dark yellow urine
- ☐ Light yellow urine
- ☐ Clear urine
- ☐ Frequent bladder infections
- ☐ Frequent kidney infections
- ☐ Other:_____

Do you suffer from any of the following:

- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Depression
- ☐ Poor memory
- ☐ Seizures
- ☐ Tics
- ☐ Abuse survivor

Female Specific:

Are you pregnant? Yes No

When was your last physical?
_____

Are your periods regular? Yes No
Length of cycle (days):_____
Duration of period (days):_____
Do you bleed between cycles? Yes No
Are you on contraceptives? Yes No
Type:_____
How long have you been using them?
_____
Reason for use:_____
_____

Do you suffer from any of the following PMS symptoms:

- ☐ Emotional
- ☐ Breast Swelling
- ☐ Breast Tenderness
- ☐ Back Pain
- ☐ Bloating
- ☐ Acne
- ☐ Cramping
- ☐ Headaches or Migraines

Do you or have you experienced:

- ☐ Hot Flashes
- ☐ Endometriosis
- ☐ Abnormal pap test
- ☐ Breast discharge
- ☐ Ovarian cysts/PCOS
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Uterine fibroids
- ☐ Pelvic infections
- ☐ Recurrent vaginitis
- ☐ Increased facial/body hair
- ☐ Tuberculosis
- ☐ STI:_____
- ☐ Weight gain more than 10 pounds
- ☐ Weight loss more than 10 pounds
- ☐ Low libido
- ☐ High libido
- ☐ Bleeding with intercourse
- ☐ Headache after orgasm
- ☐ Pain during intercourse

Pregnancy history:
# of pregnancies:_____

Year	Term or Premature	C-Section	Miscarriage	Ectopic Pregnancy	Infertility Treatment	Elective Abortion

Consent for treatment

I, _____, do herby voluntarily consent to be treated with Acupuncture, at Purity Health and Wellness, #101 - 1006 103A street SW, Edmonton, Alberta.

I understand that Acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin at certain points on or near the surface of the body. Acupuncture attempts to restore normal physiological body functions, modify or prevent pain perception.

I understand that with Acupuncture treatment there are some very slight risks and I have been made aware that certain adverse side effects may result. These include, but are not limited to: local bruising, minor bleeding, temporary pain or discomfort, fainting, and possible aggravation symptoms.

I understand that Acupuncture has been practiced safely for centuries. I also understand that no guarantees concerning its use and effects are given to me and that I am free to discontinue treatment at any time. I have had the opportunity to discuss the nature and purpose of therapies mentioned above.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above modalities of treatment.

CLIENT NAME	CLIENT SIGNATURE	DATE

PARENT / GUARDIAN NAME	PARENT / GUARDIAN SIGNATURE	DATE

CANCELLATION POLICY

A minimum of 24 hours notice is required to cancel appointments. Missed appointments without notice **will** be subject to a missed appointment fee equal to that of your scheduled appointment time. An appointment is considered missed if you arrive more than 15 minutes late. In addition, please understand that most insurance companies will not reimburse for missed appointments.