NEW PATIENT INTAKE FORM

WITH PAULA SWIREDOWSKY
AT SIMPLICITY ACUPUNCTURE

DATE: _____

PERSONAL INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY _____ PROVINCE _____ POSTAL CODE _____

EMAIL ADDRESS: _____ PHONE NUMBER: _____

OCCUPATION: _____ GENDER: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

Were you referred to our clinic?
☐ YES ☐ NO
If yes, by whom?

Do we have permission to email you regarding products and services and general health information?
☐ YES ☐ NO

Have you ever had acupuncture before? ☐ YES ☐ NO

INSURANCE INFORMATION

INSURANCE COMPANY: _____

PLAN MEMBER'S NAME: _____

POLICY/GROUP NUMBER: _____ ID NUMBER: _____

HEALTH INFORMATION

REASON FOR VISIT:

-
-
-
-
-
-

HOW LONG HAVE YOU HAD THIS CONDITION? _____

WHAT WAS THE INITIAL CAUSE? _____

WHAT MAKES IT BETTER? ☐ Warmth ☐ Cold ☐ Pressure ☐ Other _____

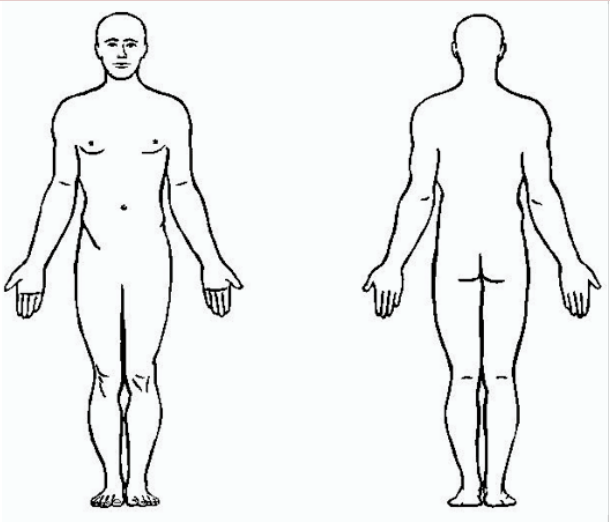
WHAT MAKES IT WORST? ☐ Activity ☐ Rest ☐ Other _____

OTHER THERAPIES: ☐ Massage ☐ Chiropractor ☐ Physiotherapy

FAMILY PHYSICIANS NAME: _____

NOTES:

PAIN CHART



INDICATE PAIN LEVEL, PAIN TYPE, AND AREAS WHERE IT OCCURS:

☐ ACUTE ☐ CHRONIC

0 1 2 3 4 5 6 7 8 9 10

☐ ACHE ☐ NUMBNESS ☐ TINGLING

☐ BURNING ☐ STABBING

- BETTER WITH:

_____

_____

- WORST WITH:

_____

_____

- SELECT AREAS OF PAIN:

☐ Neck/Shoulder
☐ Muscle
☐ Upper Back
☐ Lower Back
☐ Joint
☐ Rib
☐ Muscle Cramps
☐ Limited range of motion
☐ Other:

PERSONAL MEDICAL HISTORY

CURRENT MEDICATIONS:

-
-
-
-
-
-

CURRENT VITAMINS/ SUPPLEMENTS:

-
-
-
-
-
-

FAMILY MEDICAL HISTORY

☐ Arteriosclerosis
☐ Asthma
☐ Alcoholism/Addiction
☐ Cancer (type: _____)
☐ Depression
Diabetes: ☐ type 1 ☐ type 2
☐ Heart Disease
☐ High Blood Pressure
☐ Seizures
☐ Stroke
☐ Other: _____

☐ Allergies (to what: _____

☐ AIDS/HIV
☐ Alcoholism/Addiction
☐ Anemia
☐ Arteriosclerosis
☐ Arthritis
☐ Birth Trauma (own)
☐ Cancer (type:_____
☐ Diabetes (type:_____
☐ Emohysema
☐ Epilepsy
☐ Gall Stones
☐ Goiter
☐ Heart Disease/Attack
☐ Hepatitis (type: _____
☐ Herpes (type: _____
☐ High Blood Pressure
☐ Hyperthyroid
☐ Hyporthyroid
☐ Kidney Stones
☐ Mental Illness
☐ Pacemaker
☐ Pneumonia
☐ Ulcers
☐ STI
☐ Seizures
☐ Stroke
☐ Other: _____

NOTES:

LIFESTYLE

- WHAT ARE YOUR HOBBIES?

_____

_____

- DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO
- HOW OFTEN? _____

- DO YOU ENJOY WORK? ☐ YES ☐ NO
- DO YOU USE ANY OF THE FOLLOWING DAILY? ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Drugs
- DO YOU EXPERIENCE STRESS? ☐ YES ☐ NO
- EXPLAIN: _____

DIET

- IS YOUR APPETITE: ☐ LOW ☐ HIGH
- IS YOUR PROTEIN INTAKE: ☐ LOW ☐ HIGH
- IS YOUR VEGETABLE INTAKE: ☐ LOW ☐ HIGH

- HOW MANY LITRES OF WATER DO YOU DRINK DAILY?
  -0 1 2 3 4 5 6 7 8 9 10+

- DO YOU CONSUME ANY OF THE FOLLOWING: ☐ Coffee/Tea ☐ Pop/Juice ☐ Artificial Sweeteners ☐ Sugar ☐ Gluten ☐ Dairy products

NOTES:

GENERAL SYMPTOMS

☐ Poor Appetite
☐ Heavy Appetite
☐ Strongly like Cold drinks
☐ Strongly like Hot drinks
☐ Recent Weight Loss/Gain
☐ Bleed or Bruise Easily
☐ Peculiar Taste (describe): _____

☐ Poor Sleep
☐ Heavy Sleep
☐ Dream-Disturbed Sleep
☐ Fatigue
☐ Lack of Strength

☐ Bodily Heaviness
☐ Cold Hands or Feet
☐ Poor Circulation
☐ Shortness of Breath
☐ Fever

☐ Chills
☐ Night Sweats
☐ Sweat Easily
☐ Muscle Cramps
☐ Vertigo/Dizziness

HEAD, EYES, NOSE & THROAT

☐ Glasses/Contact lenses
☐ Eye Strain/Pain
☐ Red Eyes/ Itchy
☐ Spots in Eyes
☐ Myopia/Presbyopia
☐ Glaucoma
☐ Other Head/Neck problems:

☐ Teeth Problems
☐ Grinding Teeth/Bruxism
☐ TMJ
☐ Gum Problems
☐ Sores on Lips/Tongue
☐ Dry Mouth/Throat

☐ Sinus Problems
☐ Excessive Phlegm
☐ Swollen Glands
☐ Lump in Throat
☐ Enlarged Thyroid
☐ Recurrent sore Throat

☐ Nosebleeds
☐ Ringing in Ears
☐ Poor Hearing
☐ Earaches
☐ Headaches/Migraines
☐ Concussion

NOTES:

RESPIRATORY

- ☐ Difficulty Breathing when lying Down
- ☐ Shortness of Breath
- ☐ Tight Chest
- ☐ Asthma/Wheezing
- ☐ Difficult Inhalation
- ☐ Difficult Exhalation
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Covid 19
- ☐ Cough
  - ☐ 1. Wet
  - ☐ 2. Dry
  - ☐ 3. Thick
  - ☐ 4. Thin

Color of Phlegm:

_____

_____

_____

CARDIOVACULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Clots
- ☐ Fainting
- ☐ Chest Pain
- ☐ Tachycardia
- ☐ Heart Palpitations
- ☐ Irregular Heartbeat

NOTES:

NEUROPSYCHOLOGICAL/ MENTAL HEALTH

- ☐ Seizures
- ☐ Numbness
- ☐ Tics/ Tremors
- ☐ Poor memory/Confusion
- ☐ Abuse Survivor
- ☐ Depression
- ☐ Anxiety
- ☐ Easily Stressed
- ☐ Considered/Attempted Suicide
- ☐ Seeking Therapy

MOOD:

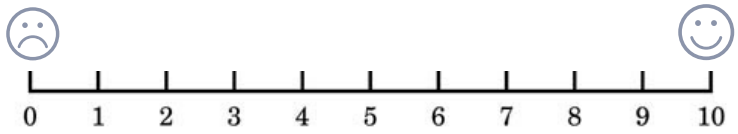
- ☐ Angry
- ☐ Irritated
- ☐ Worried
- ☐ Overthinking
- ☐ Sadness
- ☐ Fear
- ☐ Other: _____

_____

_____

- DO YOU HAVE DIFFICULTY EXPRESSING YOUR EMOTIONS OR TELLING OTHER PEOPLE HOW YOU FEEL? ☐ YES ☐ NO

- ON A SCALE OF 1-10 HOW CONTENT ARE YOU IN YOUR LIFE?



- HOW DO YOU MANAGE YOUR STRESS?

_____

_____

- HAVE YOU EXPERIENCE ANY MAJOR TRAUMA? ☐ YES ☐ NO

IF YES, EXPLAIN: _____

_____

_____

NOTES:

SKIN AND HAIR

- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Itching
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Hair Loss

Other: _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ Gas/Belching
- ☐ Hiccup
- ☐ Bad Breath
- ☐ Intestinal Pain/Cramping
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black/ Dark Stool
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Mucous in Stools
- ☐ Odorous Stools
- ☐ Rectal Pain
- ☐ Laxative Use: _____

NOTES:

GENITOURINARY

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgent Urination
- ☐ Incomplete Urination
- ☐ Waking to Urinate
- ☐ Blood in Urine
- ☐ Unable to hold Urine
- ☐ Erectile Dysfunction
- ☐ Increased Libido
- ☐ Decreased Libido

Other: _____

GYNECOLOGICAL ♀

- DATE LAST PERIOD BEGAN: _____
- LENGHT OF CYCLE (day 1- day 1): _____
- AGE MENSES BEGAN: _____
- IS YOUR CYCLE REGULAR? ☐YES ☐NO
- DURATION OF FLOW: _____
- AGE AT MENOPAUSE: _____

ARE YOU CURRENTLY USING BIRTH CONTROL? ☐YES ☐NO

If yes, for how long? _____

Name of B.C: _____

ARE YOU CURRENTLY PREGNANT? ☐YES ☐NO

If yes, how far along? _____

NUMBER OF PREGNANCIES: _____

NUMBER OF LIVE BIRTHS: _____

- ☐ PMS
- ☐ Clotting
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Vaginal Odor
- ☐ Vaginal Discharge
- ☐ Vaginal Sores/Pain
- ☐ Breast Lumps

Other: _____

NOTES: