CCF Acupuncture Clinic

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Acupuncture Intake Form

Patient Information

First Name:		Last Name:		Middle Name:
Home Telephone:	Cell Phone:	Age:	Date of Birth (DD/MM/YYYY):	Sex: M / F / Other
Home Address:				Apt #:
City:		Province:		Postal Code:
Email:		Occupation:		Insurance Company:
Emergency Contact Name:		Phone Number:		Relationship:
Family Doctor Name:		Phone Number:		City Located In:

Patient Medical Information

Have you had Acupuncture Before: ☐ Yes ☐ No If Yes, when:

Allergies/Hypersensitivities:

Current Medications:

Major Accidents/Trauma/Illnesses/Operations:

Current Chief Complaint

What brings you in today:

The onset and duration:

Concurrent treatments and therapies:

Please check any conditions you are experiencing (past and present):

General Symptoms
- ☐ Headache/migraine
- ☐ Fever
- ☐ Chills
- ☐ Sweat
- ☐ Memory loss
- ☐ Dizziness/light headedness
- ☐ Fainting
- ☐ Stress or depression
- ☐ Discoordination
- ☐ Nervousness
- ☐ Recent weight loss or gain
- ☐ Numbness pain in arms, legs

Respiratory
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Asthma

Muscle & Joint
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Pain in shoulder
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Arthritis
- ☐ Foot trouble

Ears, Nose, Throat
- ☐ Hearing loss
- ☐ Vision problems
- ☐ Glaucoma
- ☐ Ringing in ear(s)
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Dental Decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

Genitourinary System
- ☐ Frequent/painful urination
- ☐ Blood in urine or stool
- ☐ Mucus in stool
- ☐ Kidney infection or stones
- ☐ Bladder infection
- ☐ Inability to control urine

Skin
- ☐ Skin conditions or rashes
- ☐ Itching
- ☐ Bruise easily
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Hives or allergy

Gastrointestinal
- ☐ Poor appetite
- ☐ Distress from greasy foods
- ☐ Excessive hunger or thirst
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Burning in stomach
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Liver trouble or hepatitis
- ☐ Gallbladder
- ☐ Ulcers
- ☐ Colitis
- ☐ Hemorrhoids
- ☐ Hypoglycemia
- ☐ Hiatal hernia
- ☐ Metallic taste

Cardiovascular
- ☐ High or low blood pressure
- ☐ Previous stroke or TIA
- ☐ High cholesterol
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Stroke or heart attack
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Pain over heart
- ☐ Palpitations

For Women Only
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Irregular cycle
- ☐ Vaginal discharge
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Pregnant
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Hysterectomy

Your lifestyle/social history:
- ☐ Smoking
- ☐ Street Drugs
- ☐ Alcohol
- ☐ Exercise
- ☐ Diet
- ☐ Caffeine
- ☐ Occupational stress
- ☐ Personal stress
- ☐ Herbs/Homeopathic
- ☐ Vitamins

Have you (Y) or a family member (FM) had any of the following:

Y	FM		Y	FM		Y	FM		Y	FM	
☐	☐	Allergy	☐	☐	Venereal infection	☐	☐	Anemia	☐	☐	Mumps
☐	☐	Appendicitis	☐	☐	Cold Sores	☐	☐	Heart disease	☐	☐	Influenza
☐	☐	Malaria	☐	☐	Whopping cough	☐	☐	Tuberculosis	☐	☐	Gout
☐	☐	Chicken pox	☐	☐	Cancer	☐	☐	Pneumonia	☐	☐	Polio
☐	☐	Alcoholism	☐	☐	Epilepsy	☐	☐	Measles	☐	☐	Pleurisy
☐	☐	Osteoporosis	☐	☐	Multiple sclerosis	☐	☐	Goiter	☐	☐	HIV/AIDS
☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Stroke/Heart disease	☐		Birth trauma
☐	☐	Pneumatic fever	☐	☐	Parkinson's	☐	☐	Eczema	☐		Childhood illness
☐	☐	Rubella	☐	☐	Mental illness						

Print Patient Name _____ **Signature of Patient** _____ **Date** _____

Practitioner: Catherine Carleton-Fitchett, R. Ac. _____ **Date** _____