

Acupuncture Intake Form

Full Name: _____ DOB: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Occupation: _____

Phone numbers: (M) _____ (W) _____ (H) _____

Questions

What is the main concern you are receiving acupuncture for today? _____

Is this your first time getting acupuncture?

- Yes
 No

Please circle one out of each of the following pairs that describes you more in general.

Hot	Cold
Sweaty	Don't sweat easily
Thirsty	Not thirsty often
Good sleep quality	Poor sleep quality
Strong appetite	Lack of appetite
Good energy level	Poor energy level

Check all the conditions that are affecting you currently:

- Headache
- Eye problems
- Dizziness
- Fever
- Chills
- Bacterial or viral infection
- Congestion
- Shortness of breath
- Allergies
- Tinnitus
- Deafness
- Skin problems

- Indigestion
- Urinary incontinence
- Urinary retention
- Constipation
- Diarrhea
- PMS symptoms
- Menstrual irregularities

*LMP: _____

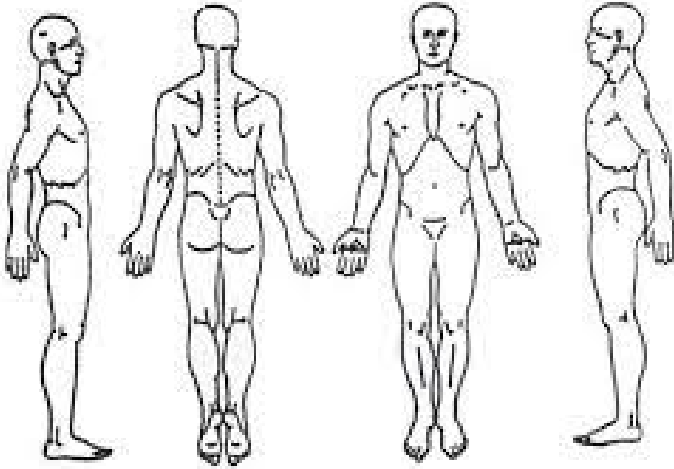
Days in cycle: _____

- Pain during menstruation
- Pregnant
- Lack of libido

*LMP= Last menstrual period

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Localized pain? If so, circle areas affected on image.



Consent for Acupuncture/Chinese Medicine Treatment

I _____ am informed of the risks and benefits of this acupuncture treatment. I understand the purpose, procedure, possible side effects and alternative options as outlined by my Naturopathic Doctor. The outcomes of accepting or refusing this treatment have been clearly explained. I am aware that acupuncture as well as other modalities of Chinese Medicine (such as aromatherapy, cupping, electrical stimulation, acupressure, or herbs) may involve a minor level of discomfort in the form of skin irritation, marks, or bruises potentially. If the treatment is not well tolerated I can request to stop, modify, or change the treatment plan if necessary. I have read the above statements and hereby give consent to Acupuncture Therapy treatment.

Patient's Signature: _____ Date: _____