EASTERN HEALING
ACUPUNCTURE CLINIC
Viet Ha, R.AC
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Tel. (613) 220-3786

Acupuncture Intake Form

Information provided on this form is confidential.
It is very important the information given is complete and accurate to assist you properly in your healing process.

Please PRINT Today's Date _____ / _______ / _________

How did you hear about us? ☐ friend ☐ relative ☐ phonebook ☐ internet ☐ walk-by
☐ healthcare referral ☐ other _________________________

Name Date of birth Age _______ Sex ☐ m ☐ f

Address

City, Province, Postal Code

Telephone (home) Work/Cell

Email Occupation

Emergency contact person/ relationship Tel

Physician Physician phone # Health insurance company

Would you like to receive our newsletters to your email ☐ yes ☐ no

What do you want treated with acupuncture?____

How long have you had this condition? The onset (start) was ☐ sudden ☐ gradual

Symptoms relieved by______________________Symptoms worsened by____________________

What medical diagnosis have you received for this condition?________________________

What other treatments have you received for this condition?_________________________

What medications are you taking and for what condition?____________________________

____

____

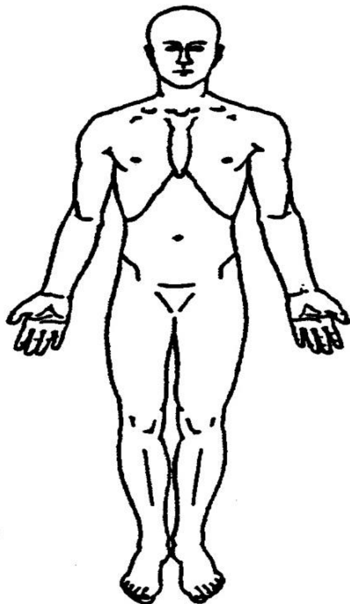
Is this your first experience with Oriental Medicine and acupuncture?_______________

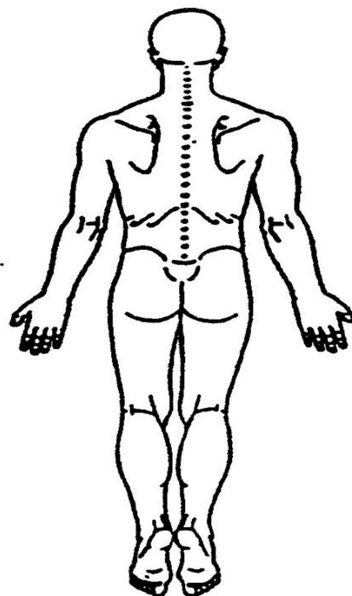
How do you feel about acupuncture?____

Are you currently pregnant? ☐ yes ☐ no

Are you presently trying to get pregnant? ☐ yes ☐ no

On the following drawings, shade in the areas where you feel should be addressed.





Past Medical History:

Have you had any of these conditions? Check all that apply

☐ AIDS/HIV	☐ Heart disease	☐ Scarlet Fever
☐ Alcoholism	☐ Hepatitis A/B/C	☐ Seasonal Allergies
☐ Allergies (food, latex)	☐ Herpes	☐ Seizures
☐ Asthma	☐ Joint replacements	☐ Sinus Infections
☐ Birth Trauma	☐ Lyme's disease	☐ Tuberculosis
☐ Cancer	☐ Lymph nodes removed	☐ Operations
☐ Diabetes	☐ Multiple Sclerosis	____________________
☐ Drug addictions	☐ Pacemaker	☐ Other conditions
☐ Emphysema	☐ Polio	____________________
☐ Fibromyalgia	☐ Rheumatic Fever	

Family Medical History (Please list any significant family illnesses – eg: diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother ____

Father ____

Siblings____

Grandparents____

Exercise and Energy

How is your energy?____

What time of day is your energy Highest?__________________Lowest?_______________________

Do you fatigue easily? ____

What kind of exercise do you do?____

How often do you exercise?____

Emotions and Sleep

How do you feel emotionally?____

Do you have (check all that apply)

☐ Panic attacks ☐ depression ☐ anxiety ☐ bad temper ☐ fear attacks ☐ nervousness ☐ poor memory ☐ difficulty in concentration

Are you in a relationship? ☐ yes ☐ no

How do you feel about your relationship?_________________________________

How do you hold stress?____

How do you relax?____

How do you feel about your work? ______________________________________

How long do you normally sleep?__________________hours per night

I have difficulties with (check all that apply)

☐ falling asleep ☐ staying asleep ☐ dream disturbed sleep

☐ Waking up at about______ am/pm and not being able to fall asleep again

Gastrointestinal

Check all that apply to you

☐ belching ☐ nausea ☐ vomiting ☐ vomiting of blood ☐ ulcers ☐ bloating ☐ acid regurgitation

☐ heartburn ☐ hernia ☐ indigestion ☐ sever stomach pain

How often are your bowel movements? ____________Time (s)/day ___________ days/week

I have (check all that apply)

☐ irregular ☐ constipation ☐ burning sensation ☐ diarhea ☐ hemorrhoids ☐ undigested food in the stool

☐ loose stool ☐ hard stool ☐ itchiness ☐ gas ☐ painful bowel movements

Eating and Drinking

☐ Poor appetite ☐ Excessive hunger ☐ Aversion to food ☐ Hunger but no desire to eat ☐ Craving for sweets ☐ Thirst with desire to drink ☐ Thirst with no desire to drink ☐ dry mouth ☐ absence of thirst

Urinary
Urination: How often? _____Times per day ____Times per night
Colour: : ☐ pale ☐ yellow ☐ turbid
I have or had (check all that apply)
☐ trouble starting stream ☐ frequent urination ☐ incontinence ☐ pain ☐ burning ☐ blood in urine
☐ dribbling ☐ kidney stones ☐ urinary tract infection ☐ other ______________________

Women
At what age did you start menstruating ____________________Number of days between cycles ______
Number of days of flow ____________________colour ____
I have or had (check all that apply)
☐ irregular menstruation ☐ heavy flow ☐ light flow ☐ no flow ☐ clots ☐ vaginal itching/burning
☐ spotting between periods Discomfort/painful period ? ☐ no ☐ yes if yes ☐ before ☐ during ☐after
Any vaginal discharge? ☐ no ☐ yes if yes what colour? _________________________________

Men
I have (check all that apply) ☐ prostatitis ☐ impotence ☐ penis discharge blood/mucosa
☐ other ____

Muscles, Joints & Bones
Do you have pain or tightness? ☐ no ☐ yes if yes where? ___________________________
The pain (check all that apply)
☐ sharp ☐ dull ☐ aching ☐ numb ☐ superficial pain ☐ deep pain ☐ burning ☐ tingling ☐ shooting
☐ pain worse/better with heat ☐ pain worse/better with cold ☐ pain worse/better with pressure
☐ pain worse in am ☐ pain worse in pm
I have (check all that apply)
☐ swollen joints ☐ arthritis/joint pain ☐ tendonitis ☐ bone pain ☐ muscle cramping ☐ muscle pain
☐ repetitive strain injury ☐ fractured bone, where _______________ ☐ other ____________________

Eyes, ears, nose, throat & head
Do you smoke? ☐ no ☐ yes if yes, __________per/day for _________________years
I have (check all that apply)
☐ frequent colds ☐ chronic runny nose ☐ frequent sore throat ☐ chronic cough ☐ coughing blood
☐ coughing up mucous ☐ pain inhaling ☐ shortness of breath on exertion/at rest ☐ asthma ☐ nose bleeds
☐ painful/red eyes ☐ poor vision ☐ see spots/floaters ☐ dizziness ☐ cold sores ☐ bleeding gums
☐ dry mouth ☐ ear pain ☐ ringing in ears ☐ clogged/popping in ears
☐ frequent headaches/migraines – describe ____

Cardiovascular
I have (check all that apply)
☐ chest pain ☐ palpitation ☐ varicose veins ☐ phlebitis ☐ cold hands and feet ☐ irregular heart beat
☐ poor circulation ☐ other ___________________________

Skin & Hair
I have or often have (check all that apply)
☐ dry skin ☐ skin rashes ☐ itching ☐ acne ☐ eczema ☐ hives ☐ hair loss ☐ premature graying
☐ other _______________________________