Downtown Brampton Wellness Centre
118 Queen St. Suite 205
Brampton, ON L6X 1A5
905-451-3963

ACUPUNCTURE INTAKE

All information is kept confidential

Date: _____(DD/MM/YY)

NAME: First _____ Last: _____ Middle: _____

Date of birth _____ (DD/MM/YYYY) Age: _____ Sex: ☐Male ☐Female

Status: ☐Single/Widowed ☐Married/Partnered ☐Divorced/Separated

HOME ADDRESS:

_____

OCCUPATION: _____ **COMPANY**: _____

Work Phone: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

May we leave messages relating to your visits? ☐Y ☐N Which Phone Number? _____

How did you hear about us? ☐Referral: _____ ☐ Website ☐ Internet Search

☐Other: _____

Do you have extended health care coverage? _____

OTHER HEALTH CARE PROVIDERS

1. _____
2. _____
3. _____

DATE OF LAST PHYSICAL: _____

1. What is your principal problem or the one area of greatest concern?

_____

2. Do you think this concern has been getting worse? Yes / No
   If so, how quickly has it increased? Gradually / Suddenly

3. What do you think caused this problem?

_____

4. How often do you experience this?

   ☐ 1-2 hrs per day ☐ About half the day ☐ Most of the day ☐ Constantly

5. How does this concern affect your daily activities?

   ☐ It does not affect them ☐ I have had to change how I do things
   ☐ I have had to stop doing some of them ☐ I am unable to perform most daily activities

6. Have you experienced this problem in the past? Yes / No If so, when? _____

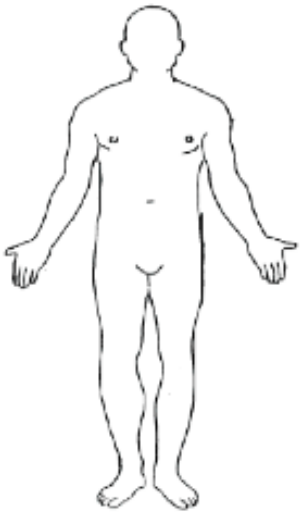
7. Which of the following treatments, if any, have you received for your complaint?
   ☐ Medication ☐ Physical Therapy ☐ Massage
   ☐ Chiropractic ☐ Acupuncture ☐ Other

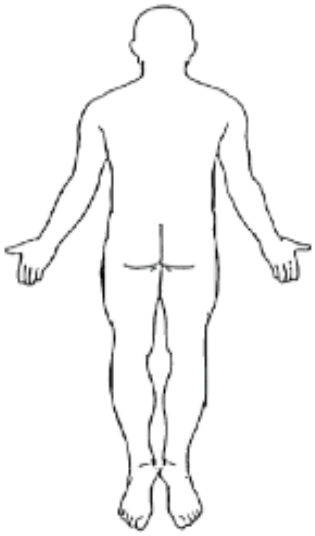
8. Which of the above treatments have benefited you the most?
   ☐ Medication ☐ Physical Therapy ☐ Massage
   ☐ Chiropractic ☐ Acupuncture ☐ Other

9. What do you expect from your visit to the clinic? _____

10. Do you have a pacemaker or any metal implants (e.g. screws)?
    If so, explain: _____

PAIN DIAGRAM





Please shade and code areas to indicate location of pain or discomfort.

P – Pins & Needles

N – Numbness

S – Spasm

T – Tenderness

A – Aches

R – Radiations

B – Burning

X - Stabbing

TRADITIONAL CHINESE MEDICINE

Please check any of the following that pertain to you:

Kidney Function

☐ Cold hands ☐ Night sweats ☐ Sweaty hands ☐ Sweaty feet
☐ Cold feet ☐ Hot flashes ☐ Thirsty ☐ Heat in hands, feet, chest
☐ Hot body temp ☐ Perspire easily ☐ Cold body temp ☐ Lack of perspiration
☐ Afternoon flushes ☐ Difficulty keeping eyes open during the day
☐ Drink water just before bed, or through the night

Spleen Function

☐ Low appetite ☐ Abrupt weight loss ☐ Easily bruised ☐ Abrupt weight gain
☐ Hemorrhoids ☐ Abdominal bloating ☐ Pensive ☐ Abdominal gas
☐ Over-thinking ☐ Worry ☐ Gurgling Noises in the Stomach
☐ Fatigue after eating ☐ Prolapsed organs [which one[s]:_____]

Stomach Function

☐ Large appetite ☐ Bad breath ☐ Bleeding, Swollen, Painful Gums
☐ Heartburn ☐ Mouth sores [cankers] ☐ Belching ☐ Hiccups
☐ Acid regurgitation ☐ Stomach pain ☐ Vomiting ☐ Burning sensation after eating
☐ Ulcer [previously diagnosed]

Lung Function

☐ Cough ☐ Nose Bleeds ☐ Sinus congestion ☐ Overall achiness in body
☐ Dry mouth ☐ Stiff neck ☐ Dry throat ☐ Stiff shoulders
☐ Dry nose ☐ Sore throat ☐ Dry skin ☐ Difficulty breathing
☐ Sneezing ☐ Smoke cigarettes ☐ Headache ☐ Alternating fevers + chills
☐ Nasal discharge [colour:_____] ☐ Allergies [to what?_____]

Heart function

☐ Palpitation ☐ Anxiety ☐ Soreness on the tip of the tongue
☐ Restlessness ☐ Frequent dreams ☐ Mental confusion ☐ Waking unrefreshed
☐ Chest pain traveling to shoulder ☐ Drink coffee [#cups/day:_____]

Urination

☐ Normal Colour ☐ Profuse ☐ Dark Yellow ☐ Strong Odour
☐ Clear ☐ Burning ☐ Cloudy ☐ Reddish
☐ Scant ☐ Urgent ☐ Painful ☐ Frequent

Liver + Gallbladder function

☐ Chest pain	☐ Anger easily	☐ Irritability	☐ Unable to adapt to stress
☐ Frustration	☐ Depression	☐ Numbness	☐ Bitter taste in the mouth
☐ Neck tension	☐ Muscle spasms	☐ Muscle twitching	☐ Muscle cramping
☐ Shoulder tension	☐ Seizures	☐ Convulsions	
☐ Limited Range of Motion [Neck]		☐ Limited Range of Motion [Shoulder]	
☐ Headache at the top of the head		☐ High-pitched ringing in the ears	
☐ Skin rashes [where:_____]		☐ Gallstones [previously or currently]	
☐ Alternating diarrhea + constipation			

Urinary Bladder function

☐ Frequent cavities	☐ Sore knees	☐ Weak knees	☐ Excessive hair loss
☐ Low back pain	☐ Bladder Infections	☐ Memory problems	☐ Easily startled
☐ Wake during the night twice or more to urinate		☐ Cold sensation in the knees	

Overall

☐ Excess Phlegm	☐ Frequent Colds / Flu	☐ Low Energy	☐ High Energy
☐ Dizziness	☐ Mental Heaviness	☐ Mental Sluggishness / Fogginess	
☐ Preference for hot drinks	☐ Preference for cold drinks		
☐ Generally Hot person	☐ Generally cold person		

MEDICAL HISTORY/ OTHER

1. Please list all medications you are currently taking (including vitamins and over the counter medication).

2. If female, when was your last period? _____

3. If female, are you pregnant? Yes / No / Unsure

4. Below are several lists of diseases and conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Please check all that apply.

Diseases

☐ AIDS	☐ Anaemia	☐ Cancer	☐ Chicken Pox	☐ Diabetes
☐ Eczema	☐ Heart Disease	☐ Hepatitis A B C D	☐ Influenza	☐ Mental Disorder(s)
☐ Pneumonia	☐ Psoriasis	☐ Rheumatic Fever	☐ Smallpox	☐ Stroke / ITA
☐ Thyroid	☐ Arthritis	☐ Tuberculosis	☐ Other	_____

Cardiovascular & Pulmonary System

☐ Chest pain	☐ Heart problems	☐ Varicose veins	☐ Ankle/calf swelling	☐ Irregular heartbeat
☐ Stroke	☐ Blood pressure	☐ Lung problems	☐ Congestion	☐ Shortness of breath

Gastrointestinal System

☐ Abnormal appetite	☐ Gas / bloating	☐ Upset stomach	☐ Frequent nausea	☐ Colitis
☐ Heartburn	☐ Diarrhea	☐ Excessive thirst	☐ Ulcers	☐ Hemorrhoids
☐ Vomiting	☐ Weight trouble	☐ Gall bladder	☐ Constipation	☐ Dark / bloody stool
☐ Abdominal cramps	☐ Liver problems	☐ Irritable bowel		

Genitourinary & Musculoskeletal Systems

☐ Bladder trouble	☐ Vaginal pain	☐ Breast pain/lumps	☐ Sexual dysfunction	☐ Difficulty chewing
☐ Joint pain/stiffness	☐ Menstrual cramps	☐ Vaginal infection	☐ Menstrual irreg'y	☐ Low back pain
☐ Clicking jaw	☐ Neck pain	☐ Discoloured urine	☐ Painful urination	☐ Prostate problems
☐ Walking difficulties	☐ Pain b/w shoulders	☐ Wrist / hand pain	☐ Arm pain	☐ General stiffness

Nervous System / EENT

☐ Nervousness	☐ Numbness	☐ Fainting	☐ Paralysis	☐ Depression
☐ Confusion	☐ Forgetfulness	☐ Dizziness	☐ Tingling	☐ Vision problems
☐ Ears ringing	☐ Ears buzzing	☐ Stress	☐ Dental problems	☐ Sore throat
☐ Vertigo	☐ Hearing difficulties	☐ Grinding teeth		

INFORMED CONSENT FOR ACUPUNCTURE

Patient Name: _____

Attending ND: _____

Recommended Procedure:

Acupuncture:_____

Risks include:
- Pain, bruising, or injury
- Fainting or puncturing an organ

I, the undersigned, do hereby acknowledge that I have been informed of and understand the nature and purpose of the recommended acupuncture treatment procedures and have discussed this to my satisfaction with my naturopathic doctor. I further acknowledge that I understand the expected benefits, potential risks and side effects, the likely consequences of not following the after-care instructions, and what alternate courses of action are available to me, including having no treatment. As a result, I hereby voluntarily consent to the recommended treatment as specified above.

_____ _____

Patient Name (please print) Patient Signature

_____ _____

Signature of Attending ND Date