Acupuncture Intake & Consent Form

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Personal Information:

Name_____ Date_____
Birthdate _____ Gender_____
Home phone_____ Cell phone_____
Mailing Address_____
Email_____
Emergency Contact Name & Number

_____

Dr / Primary Health Practitioner Name & Number

_____

Health Concerns:

Please tell me the reason for your visit today:

How long have you had this condition?

What seems to make it better?

What seems to make it worse?

Please tell me any other concerns you may have about your health:

Have you had acupuncture before? YES / NO

Please list any current therapies, vitamins, supplements, herbs or pharmaceutical medication you are currently taking, as well as how often:

Please tell me about any of the following that apply:

Stress

_____

_____

Substance use / cravings

_____

_____

Exercise

_____

_____

Self Care

_____

Your Medical History
Appendicitis
Asthma
Cancer
Diabetes
Emphysema
Epilepsy
Heart Disease
Hepatitis
High Blood Pressure
Pacemaker
Stroke
Thyroid

Family Medical History
Alcoholism
Asthma
Cancer
Diabetes
Heart Disease
High Blood Pressure
Stroke
Seizures
Allergies _____
Other _____

Habits (& how often?)
Caffeine Salt
Sugar/Sweets
Alcohol
Tobacco Marijuana
Other Drugs

Disorders_____
Allergies_____
Childhood Disease_____
Surgery_____
Other _____

Average Diet (what, and what time?):
Morning _____
Lunch _____
Dinner _____
Snacks _____
Thirst : # Glasses of water per day?_____ Do you prefer hot or cold drinks?_____

Energy drop in the day? (What time_____) When do you have the most energy? (Time_____)

General: **(Please check any that are a concern right now (N), or have been in the past (P))**

Fever		Hard to fall asleep		Change in appetite		Peculiar taste/smell	
Chills		Wake up easily		Poor appetite		Tremors	
Fatigue		Night Sweat		Heavy appetite		Bleed/bruise easily	
Insomnia		Sweats easily		Thirst		Other_____	

Skin & Hair:

Rashes		Eczema		Hair Loss		Psoriasis	
Itching		Hives		Acne		Other_____	

Head, Eyes, Ears, Nose & Throat:

Dizzy getting up		Headaches		Dry mouth/throat		Sinus problems	
Dizzy laying down		Migraines		Nose bleeds		Poor hearing	
Night blindness		Sore eyes		Seeing spots/ floaters		Recurrent sore throat	
Blurry Vision		Ear aches		Grinding teeth		Sores on lips/tongue	
Ringing in ears		Gum problems		Excess saliva		Mucus/Phlegm	

Cardiovascular & Respiratory:

High blood pressure		Bronchitis		Chest pain		Varicose veins	
Chronic cough		Fainting		Cold hands / feet		Swelling hands / feet	
Irregular heartbeat		Shortness of breath		Asthma		Other_____	

Musculo-skeletal:

Arthritis		Joint pain		Muscle pain		Other_____	
Upper back pain		Lower back pain		Neck pain			

Genito-urinary:

Frequent urination		Wake up to urinate		Kidney stones		Dysuria (painful urination)	
Urgency to urinate		Impotence		Unable to hold urine		Hematuria (blood in urine)	

Gastrointestinal:

Gurgling noises		Strong odor		Pain or cramping		Hemorrhoids	
Bloody/black stool		Bad breath		Belching		Nausea	
Diarrhea		Rectal pain		Laxative use		Gas	
Vomiting		Constipation		Rectal prolapse		Other_____	

Bowel movements: ____/day

Neurophysiological:

Anxiety		Fear		Areas of numbness		Depression	
Easily stressed		Poor memory		Anger/irritable		Mood swings	

Gynecological:

Clotting		Lower abdominal pain		Menopause Age:____		Perimenopause	
Discharge		Spotting		Fertility concerns		Endometriosis	
Pregnant Due:_____		# Pregnancies _____		# Births _____		Birth control Type:_____	

Last Period: _____
Time Between Periods: _____
Duration: _____
Cramps: Before During After
Flow: Heavy Med Light
Colour: Dark Med Light

ADDITIONAL NOTES:

Treatment Information

It is best not to arrive on an empty stomach, and to use the washroom before your treatment. If possible, please avoid coffee, cigarettes, or large meals one hour before and after treatment. Cell phones or other electronic devices should be turned off. The first visit will begin with an intake and consent process. All information you share with me is held in strict confidence at all times. If you have any questions or concerns about treatment, you may ask at any time. I will make a personalized diagnosis and tailor an acupuncture prescription based on your individual health picture at each visit. The more information you are able to share about your present state of health, your health history, and any health-related concerns you have, the more effective your treatment will be. Once the needles are inserted, you will be asked to relax for about half an hour. Do not get up from the table or move around when the needles are in place. If you need to move or get up, let me know and I will remove the needles. Try not to have anything strenuous planned after a treatment, it is best if you can plan to relax and take it easy. Your body is in healing mode and the acupuncture will continue to take effect for anywhere from a few hours to a few days. Acupuncture works on a physical, emotional and psychological level. You may notice effects physically, mentally and/or emotionally. This is normal. Occasionally, some people may notice a flare up of symptoms after a treatment, this is not common, and typically only happens just at the beginning of a course of treatment. It is part of the healing process. Let your practitioner know at your next session, as well as any other changes you may notice. Acupuncture has a cumulative effect. It works best with regular visits. Whatever your reason for seeking treatment, you should notice some improvement after one visit, but the effects will be greater with each session. Acupuncture works with your own body's strength and energy. It is not intended to take the place of your usual health care regimen, but it can be used on it's own or to compliment other forms of care. I may choose to use additional Chinese medicine modalities such as cupping, guasha and food therapy suggestions during your treatment to supplement your healing plan. Using these additional therapies is based on your TCM diagnosis at each visit, and may vary based on your symptoms being presented. These are *always optional*, and your verbal consent will be required.

Consent

Acupuncture is considered very safe. Needles are sterile and disposed of after each use. They are very thin and inserted shallowly. Acupuncturists are trained to avoid injury and pain. Some side effects or risks may include slight bleeding or bruising, mild discomfort during needle insertion, or, in very rare cases, dizziness or nausea. Should you experience any of these symptoms, please let your acupuncturist know right away. Always inform your acupuncturist if there is any chance you might be pregnant, if you have a bleeding disorder such as hemophilia, if you use a pacemaker, if you are currently taking blood-thinning medication, or if you feel weak or hungry before starting treatment.

I, _____, am aware of the risks and benefits of acupuncture. I understand this treatment is not a substitution for my primary care by a medical physician. I understand I can stop treatment at any time. I hereby give my informed consent to receive acupuncture treatment from Cydney Gray Rumball.

Signature_____ Date_____

Witness _____ Date_____