pointspace

PATIENT INTAKE FORM

Date: _____ Name: _____

Name of Parents/Guardians (if under 18): _____

Address: _____

_____

Date of Birth: _____ Age: _____ Occupation: _____

Telephone: Mobile _____ Home_____

Email: _____

Emergency contact name & phone number: _____

Name & address of GP: _____

_____

Current medications / dosages: (Include over the counter, supplements, vitamins, herbs)

In order of importance, reasons for seeking treatment:

1.

2.

3.

How did you hear about us? _____

Referred by: _____

Have you had acupuncture before? ____ From whom? _____

Signature: _____ Date: _____

Name _____ **Date** _____

1. Health History: Have you ever been diagnosed with any of the following?

__ Tension headaches
__ Migraine headaches
__ TMJ disorder
__ Back pain or sciatica
__ Chest pain or angina
__Abdominal pain
__ Pelvic or genital pain
__ Rheumatoid arthritis
__ Osteoarthritis
__ Fibromyalgia
__ Chronic fatigue syndrome
__ Bone fracture/joint sprain
__ Muscle spasm or tremor
__ Carpal tunnel syndrome
__ Tennis elbow
__ Frozen shoulder
__ Peripheral neuropathy
__ Shingles (herpes zoster)
__ Coronary disorder or heart attack
__ Lung or respiratory disorder
__ Liver disease or hepatitis
__ Urinary or bladder infection
__ Kidney disorder or kidney stones
__ Gallbladder disorder or gall stones
__ Spleen or lymphatic disorder
__ Gastric or peptic ulcer
__ Irritable bowel syndrome or colitis
__ Diabetes mellitus
__ Hypoglycaemia
__ Thyroid disorder
__ Dysmenorrhoea (painful menstruation)
__ Pre-menstrual syndrome
__ Prostate or vaginal disorder
__ Skin disorder, eczema, psoriasis
__ Raynaud's disease
__ Deafness or tinnitus
__ High blood pressure
__ Low blood pressure
__ Stroke
__ Seizure or epilepsy
__ Concussion
__ Cancer or tumours
__ HIV+ or AIDS
__ Multiple sclerosis
__ Polio or mononucleosis
__ Allergies or hayfever
__ Asthma or bronchitis
__ Tuberculosis
__ Pneumonia
__ Attention deficit disorder
__ Obsessive-compulsive
__ Panic attacks or phobias
__ Major depression
__ Schizophrenia

2. Accidents: Have you ever been injured in any of the following types of accidents?

__ Automobile accident
__ Athletic injury
__ Work-related accident
__ Surgical complication
__ Accident at home
__ Other accident

3. Current Conditions: In the past year, have you noticeably experienced any of the following?

__ Pain in legs or feet
__ Pain in arms, wrist, hands
__ Cold hands or cold feet
__ Swollen ankles or feet
__ Stiff, aching joints
__ Neck or shoulder tension
__ Grinding your teeth
__ Rapid heart beat
__ Excessive sweating
__ Hyperventilation
__ Dizziness or fainting
__ Large weight gain or weight loss
__ Overeating or binge eating
__ Under eating or poor appetite
__ Craving for sweets or chocolate
__ Craving for drugs or alcohol
__ Dissatisfaction with job
__ Bored or uninterested in things
__ Loneliness or lack of affection
__ Sex life not satisfying
__ Thoughts of killing yourself
__ Worried about finances
__ Sinus congestion
__ Colds, flu or chills
__ Sore throat
__ Nausea or vomiting
__ Diarrhoea
__ Constipation
__ Blurred vision
__ Lethargy, fatigue
__ Difficulty sleeping
__ Disturbing dreams
__ Relationship problems

4. Substances or Medications: In the past several months, did you regularly take any of these?

__ Cigarettes or cigars
__ Several cups of coffee/day
__ Glass or beer or wine
__ Liquor or mixed drinks
__ Aspirin
__ Prescribed pain reliever medication
__ Recreational drugs/marijuana
__ Several cans of soft drink/day
__ Sleeping pills
__ Anti-anxiety pills
__ Anti-depressant pills
__ Blood pressure pills