Happy Family Wellness Clinic

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Acupuncture Patient Intake/Health History Form

An accurate health history is important to ensure that it is safe for you to receive an acupuncture treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. This information may be shared amongst other health custodians or circle of care for purpose of your health care.
24 hour cancellation notice is required or a missed appointment fee will be charged.

Name:______________________________Email:______________________________

Home:(________)____________________ Work:(________)_________Cell:(________)____________________

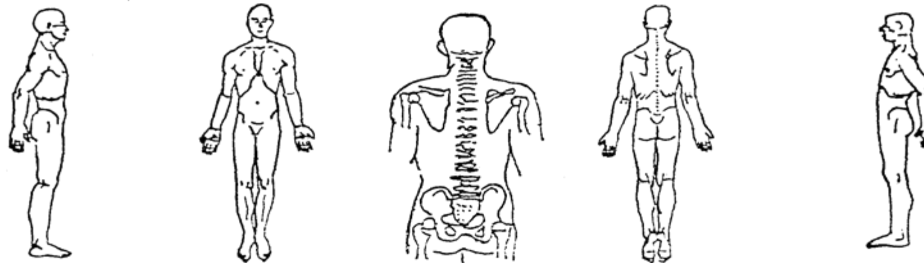
Address:____________________City:____________________Postal Code:____________________

Date of birth:_____/_____/___ Occupation:____________________First time for Acupuncture: YES / NO
D M Y

Family Physician: ____________________ Address:______________________________

Who can we thank for referring you here?____________________ If Doctor – Address:____________________

Reason for Acupuncture Treatment:
Indicate your problem by shading in the area



Medical Information

1. **Are you currently receiving any therapy from another health care practitioner?**
   - ☐ Medical Doctor
   - ☐ Massage Therapist
   - ☐ Chiropractor
   - ☐ Physiotherapist
   - ☐ Naturopath
   - ☐ Dietitian
2. **Are you taking any medications? YES / NO. If "YES", what?**____________________
3. **Are you pregnant? YES / NO. If "YES", what trimester?**____________________
4. **Lifestyle Choices / Habits (please check all that applies to you):**

   ☐ Exercise ☐ Alcohol/Drugs ☐ Coffeine ☐ Smoking ☐ Other____________________
5. **Surgeries YES / NO (if "YES", please indicate nature and date of procedure)** ____________________

   ____
6. **Accidents YES / NO (if "YES", please indicate the date of accident)** ____________________
7. **Current Level of Stress** ☐ Low ☐ Moderate ☐ High
8. **General Health Status:**

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check if you are experiencing or have experienced any conditions below:

Regional Areas of Concern

☐ Neck/ Head/ Face
☐ Shoulder
☐ Arm
☐ Chest/ Abdomen
☐ Spine
☐ Pelvis
☐ Hip
☐ Leg
☐ Hands/ Feet
☐ Muscle weakness
☐ Muscle soreness
☐ Pins, plate, implants
☐ Artificial joints
☐ Cosmetic implants
☐ Joint problems (arthritis, etc)
☐ Osteoporosis
☐ Other

What? ________________

Neurological

☐ Epilepsy
☐ Multiple Sclerosis
☐ Loss of sensation
☐ Neuritis
☐ Other

What? ________________

Respiratory

☐ Chronic cough
☐ Bronchitis
☐ Shortness of breath
☐ Asthma
☐ Emphysema
☐ Other

What? ________________

Infectious Diseases

☐ Infectiuos skin conditions
☐ Tuberculosis
☐ Hepatitis
☐ HIV
☐ Other

What? ________________

Gastrointestinal

☐ Prolonged constipation
☐ Irritable Bowl Syndrome
☐ Chronic abdominal discomfort
☐ Diarrhea
☐ Other

What? ________________

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Chronic Congestive Heart Failure
☐ Heart Disease
☐ Myocardinal Infarction
☐ Phlebitis
☐ Cerebro-vascular accident (Stroke)
☐ Presence of a pace maker or similar device
☐ Hemophilia
☐ General circulatory disorder
☐ Varicose veins
☐ Dizziness
☐ Chest pain
☐ Other

What? ________________

Renal

☐ Kidney stones
☐ Dialysis
☐ Nephritis
☐ Other

What? ________________

Allergies

☐ Known allergies or Hypersensitivities

What? ________________

☐ Anaphylaxis
☐ Skin irritations

Medical Conditions

☐ Diabetes
☐ Cancer
☐ Skin conditions

What? ________________

Reproductive

☐ Pregnancy
☐ Endometriosis
☐ Pelvic Inflammatory Disease
☐ Prostate condition

Special Senses

☐ Vision Problems
☐ Vision loss
☐ Hearing loss
☐ Altered taste
☐ Altered smell

CONSENT TO TREATMENT FOR ACUPUNCTURE THERAPY

I, ________________________________understand that acupuncture, and other modalities of Chinese Medicine (including acupressure, massage, herbs, aromatherapy, cupping, and electrical stimulation), may cause minor discomfort, and may irritate the skin or leave a mark or bruise.

The therapists have provided me with information relevant to the treatment for the above listed complaints.

My therapist has thoroughly explained alternative treatment where applicable and relevant, as well as possible risks and side-effects of my therapists' proposed treatment plan.

The consequences of having treatments or not having treatments have been explained to me. I have been informed that I may request the therapist to stop, modify or change the treatment plan.

I have read above and understand the consent to Acupuncture Therapy treatment.

Patient's Signature________________________________ Date:____________________________

Therapist's Signature______________________________ Date:____________________________