Earthsea Acupuncture Intake Form

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Personal Information:

Name _____ Today's Date _____
Birthdate _____ Care Card # _____
Phone Number_____ 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? _____ Chinese Herbal Medicine? _____

Injuries & Hospitalizations

Please note any serious injuries, surgeries and/or hospitalizations you have had.

_____

_____

Medications & Supplements

Please list any medications and/or supplements you are currently taking.

_____
_____

Diet (foods; avg # of meals/day)

_____
_____

Health History

Please check conditions and symptoms you currently have or have had in the past. Write an **F** next to any that may apply to your family medical history.

- ❑ Appendicitis
- ❑ Diabetes
- ❑ Rapid weight loss
- ❑ Migraines
- ❑ Stroke
- ❑ Bronchitis
- ❑ Asthma
- ❑ Respiratory problem
- ❑ Pneumonia
- ❑ Eczema
- ❑ Chronic pain
- ❑ Dizziness / vertigo
- ❑ Swollen lymph nodes
- ❑ Tuberculosis
- ❑ Fungal infection
- ❑ Emphysema
- ❑ Hernia
- ❑ Epilepsy
- ❑ Cancer
- ❑ Ringing in the ears
- ❑ Bleeding disorders
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Palpitations
- ❑ Pacemaker
- ❑ Seizures
- ❑ Thyroid disorder
- ❑ Ulcers
- ❑ Stomach disorders
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Hepatitis
- ❑ Arthritis
- ❑ HIV
- ❑ Herpes
- ❑ Menstrual disorders
- ❑ Vaginal infection
- ❑ Venereal disease
- ❑ Urinary tract infection
- ❑ Miscarriage
- ❑ Fatigue
- ❑ Insomnia
- ❑ Restlessness
- ❑ Depression
- ❑ Anxiety
- ❑ Bi-polar disorder
- ❑ Psychiatric care
- ❑ Other: _____
- ❑ Other: _____

Allergies _____

_____

Substance Use/Cravings (circle)

Caffeine	Alcohol	Other drugs
Salt	Tobacco	Other _____
Sugar/sweets	Marijuana	

History: _____

Thirst : Thirst level 1-10 scale: ___ Prefer hot drinks Prefer cold drinks

General: Energy level 1-10 scale: ___

Fever	Bleed / bruise easily	Peculiar taste / smell
Chills	Sudden energy drop at ___	Bitter taste in mouth
Sweat easily	Fatigue	Other _____
Spontaneous sweating	Tremors	

Sleep: Quality 1-10 scale: ___

Difficulty falling asleep	Frequent night-urination	Grinding teeth at night
Wake up easily	Vivid intense dreams	Night sweats
Wake up a lot at night (difficulty staying asleep)	Difficulty falling back asleep	Other _____
	Nightmares	

Skin & Hair:

Rashes	Hives	Psoriasis
Itching	Hair loss	Other_____
Eczema	Acne	

Head, Eyes, Ears, Nose & Throat:

Dizziness getting up	Poor hearing	Grinding teeth
Headaches	Night blindness	Sores on lips / tongue
Dry Mouth / Throat	Sore eyes	Ringing in ears
Sinus problems	Seeing spots	Gum problems
Dizziness laying down	Recurrent sore throat	Excess saliva
Migraines	Blurry vision	Mucus /Phlegm (please describe)
Nose bleeds	Ear aches	Other _____

Cardiovascular & Respiratory:

Palpitations	Varicose veins	Shortness of breath
High blood pressure	Cough	Asthma
Bronchitis	Fainting	Swelling hands / feet
Chest pain	Cold hand / feet	Hypochondrial distension
Chest oppression	Irregular heart beat	Other _____

Musculo-skeletal:

Arthritis	Muscle pain	Back pain
Joint Pain: _____	Neck pain	Other _____

Genito-urinary:

Colour: _____	Painful urination	Blood in urine
Frequent urination	Urgency to urinate	Other _____
Wake up to urinate	Impotence	
Kidney stones	Unable to hold urine	

Digestive:

Increase in appetite	Nausea	Other _____
Poor appetite	Heart burn	
Belching	Bad breath	

Gastrointestinal:

Bowel movement ____ / day	Constipation	Gas
Firm Soft Loose	Abdominal pain or cramps	Vomiting
Colour: _____	Hemorrhoids	Rectal Prolapse
Strong bowel odour	Rectal pain	Other _____
Diarrhea	Laxative use	
Bloody / Black stools	Abdominal bloating/distension	

Neurophysiological/ Emotional:

Anxiety	Depression	Anger / bad temper
Fear	Easily stressed	Mood swings
Areas of numbness	Poor Memory	Other_____

Gynaecological:

Pregnant (Due _____) # of Pregnancies _____ # of Births _____ Premature births _____ Birth control (type _____) Miscarriages Fertility concerns Menopause (age_____)	Cycle length (1st day of period to next 1st day): _____ days 1st day of last period _____ Duration of period _____ Flow: Heavy Med Light Colour: Dark Light Med Cramps: Before/During/After	❑ Lower abdominal pain ❑ Breast swelling/ tenderness ❑ Bloating ❑ Spotting ❑ Clots ❑ Discharge Other _____