First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confirmation: E-mail / Phone / Text

DOB (D/M/Y): \_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ How do you identify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AHC # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Intake Form**

Please fill out the intake form to the best of your knowledge. You’re more than welcome to add any additional information that may not be on the intake.

Have you had acupuncture before? Yes No

Have you consulted a physician/dentist about the condition that you are currently seeking treatment? Yes No

Main Concerns:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical History:

Mother’s side: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s side: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had any operations? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any injuries or any past injuries? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications / Supplements / Vitamins - Please list any that you are currently taking and reason for use:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? Please list and explain what the reaction to them is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain:

Please clearly mark any areas of pain:

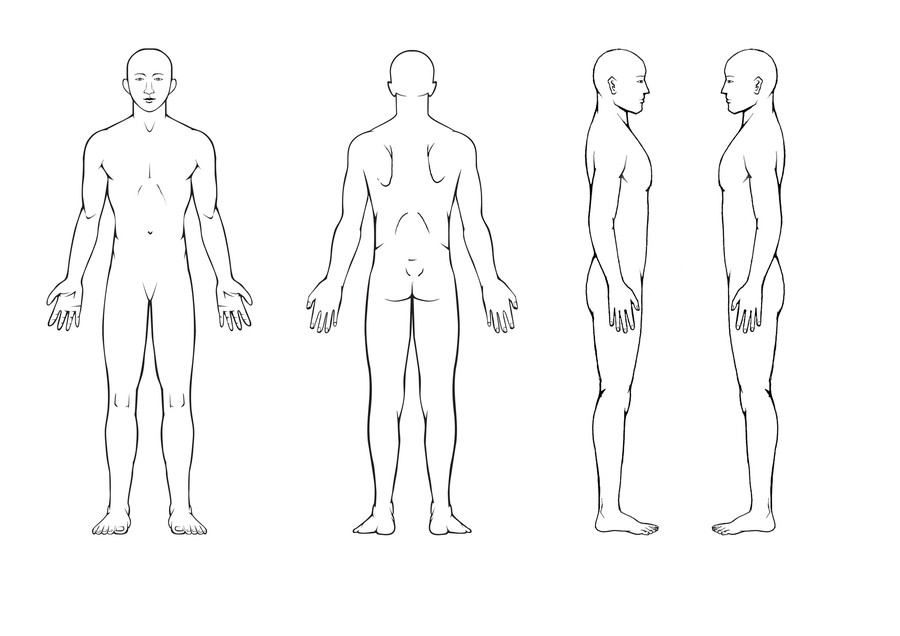
Key: **XXX** - Pain / **OOO** - Tingling / **NNN** - Numbness / **SSS** - Stabbing

Does anything make the pain worse?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What helps alleviate this pain?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Lifestyle:

Do you participate in any physical activities? Please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do to relax and alleviate stress:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the many causes of stress in your life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dietary Information:

Do you eat breakfast? Yes No

How much water do you drink each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many servings of fruit and vegetables do you eat each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol:\_\_\_ (# / week) Coffee/Tea: \_\_\_ (# / week) Pop: \_\_\_ (# / week) Tobacco: \_\_\_ (# / week)

How is your appetite? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you crave certain foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel thirsty often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any unusual tastes in the mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep: Heart: Skin & Hair: Lungs:

How many hours of sleep ☐ High blood pressure ☐ Itchy skin ☐ Shortness of breath

do you get at night? \_\_\_\_\_ ☐ Low blood pressure ☐ Dry skin ☐ Chest tightness

☐ Insomnia ☐ Chest pains ☐ Oily skin ☐Chest oppression

☐Nightmares ☐ Palpitations ☐ Rashes ☐ Asthma/wheezing

☐ Waking tired ☐ Fainting ☐ Hives ☐ Chronic Cough

☐ Waking frequently ☐Irregular heart beat ☐ Ulcerations ☐ Dry cough

☐ Dream disturbed sleep ☐ Fast heart beat ☐ Eczema ☐ Cough with phlegm

☐ Problems staying asleep ☐ Slow heartbeat ☐ Psoriasis ☐Other:\_\_\_\_\_\_\_\_\_

☐ Problems falling asleep ☐ Feel light headed ☐Shingles

☐ Other:\_\_\_\_\_\_\_\_\_ ☐ Phlebitis ☐ Acne

☐ Orthostatic hypotension ☐ Fungal Infections

☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Hair loss

☐ Brittle hair

☐ Premature greying

☐Other:\_\_\_\_\_\_\_\_

Head, Eyes, Ears, Nose & Throat: Gastrointestinal: Genito-Urinary:

☐ Glaucoma # of bowel movements/day \_\_\_ ☐ Frequent urination

☐ Cataracts ☐Constipation ☐Scanty urination

☐Poor vision ☐ Diarrhea ☐Painful urination

☐ Night blindness ☐ IBS ☐ Burning urination

☐ Blurred vision ☐ Ulcerative colitis ☐ Cloudy urination

☐ Eye strain ☐ Colitis/enteritis ☐Urination at night

☐ Red eyes ☐ Hard stools ☐Retention of urine

☐Itchy eyes ☐Loose stools ☐Incontinence

☐ Spots in eyes ☐ Black stools ☐ Dark yellow urine

☐Floaters in eyes ☐ Mucus in stools ☐Light yellow urine

☐Poor hearing ☐Blood in stools ☐ Clear urine

☐Ringing in ears ☐ Vomiting ☐Frequent bladder infections

☐ Earaches ☐Nausea ☐Frequent kidney infections

☐Sinus problems ☐Gas ☐Other:\_\_\_\_\_\_\_\_

☐Nosebleeds ☐ Bloating after meals

☐Swollen glands ☐ Undigested food in stool Do you suffer from any

☐ Lumps in throat ☐ Acid regurgitation of the following:

☐ Sore throat ☐ Gastritis ☐ Anxiety

☐ Dry mouth ☐Stomach cramps ☐Irritability

☐ Clears throat often ☐ Intestinal cramps ☐ Easily stressed

☐ Tongue sores ☐Hemorrhoids ☐ Depression

☐ Gum disease ☐ Other:\_\_\_\_\_\_\_\_ ☐Poor memory

☐ Sore gums ☐Seizures

☐Bleeding gums ☐ Tics

☐Cold sores ☐Abuse survivor

☐Problems with TMJ

☐ Grinding teeth

☐ Soft teeth

☐ Multiple cavities

Female Specific: Do you or have you experienced:

Are you pregnant? YES NO ☐Hot Flashes

When was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Endometriosis

Are your periods regular? YES NO ☐ Abnormal pap test

Length of cycle (days): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Breast discharge

Duration of period (days): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Ovarian cysts/PCOS

Do you bleed between cycles? YES NO ☐Vaginal discharge

Are you on contraceptives? YES NO ☐ Vaginal dryness

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Uterine fibroids

How long have you been using them? \_\_\_\_\_\_\_\_\_\_\_\_ ☐Pelvic infections

Reason for use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Recurrent vaginitis

Do you suffer from any of the following PMS symptoms: ☐Increased facial/body hair

☐ Emotional ☐Tuberculosis

☐ Breast Swelling ☐ STI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Breast Tenderness ☐Weight gain more than 10 pounds

☐Back Pain ☐ Weight loss more than 10 pounds

☐ Bloating ☐ Low libido

☐ Acne ☐ High libido

☐ Cramping ☐Bleeding with intercourse

☐ Headaches or Migraines ☐ Headache after orgasm

☐ Pain during intercourse

Pregnancy History:

# of pregnancies: \_\_\_\_\_\_\_\_

| Year | Term or Premature | C-Section | Miscarriage | Ectopic Pregnancy | Infertility Treatment | Elective Abortion |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Consent for treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby voluntarily consent to be treated with Acupuncture, at Purity Health and Wellness, #101 - 1006 103A street SW, Edmonton, Alberta.

I understand that Acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin at certain points on or near the surface of the body. Acupuncture attempts to restore normal physiological body functions, modify or prevent pain perception.

I understand that with Acupuncture treatment there are some very slight risks and I have been made aware that certain adverse side effects may result. These include, but are not limited to: local bruising, minor bleeding, temporary pain or discomfort, fainting, and possible aggravation symptoms.

I understand that Acupuncture has been practiced safely for centuries. I also understand that no guarantees concerning its use and effects are given to me and that I am free to discontinue treatment at any time. I have had the opportunity to discuss the nature and purpose of therapies mentioned above.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above modalities of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name Parent / Guardian Signature Date

**CANCELLATION POLICY**

**A minimum of 24 hours notice is required to cancel appointments.** Missed appointments without notice **will** be subject to a missed appointment fee equal to that of your scheduled appointment time. An appointment is considered missed if you arrive more than 15 minutes late. In addition, please understand that most insurance companies will not reimburse for missed appointments.