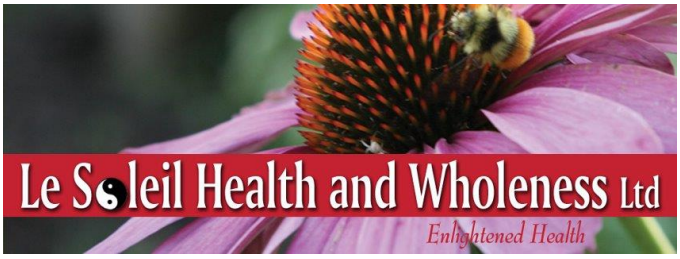


Valerie Plante R.Ac.
Acupuncture Intake Form

Today's Date:	Name:	
Date of Birth (D/M/Y):	Age:	
Occupation:	Male ☐ Female ☐	
Address:	Postal Code:	
E-mail:		
Main Telephone Number:	Home:	Work:
How did you hear about the clinic?		
Family Physician Name and Phone Number:		
Emergency Contact Person Name:	Phone #:	Relation:
Is this your first time experiencing Oriental medicine and Acupuncture:		

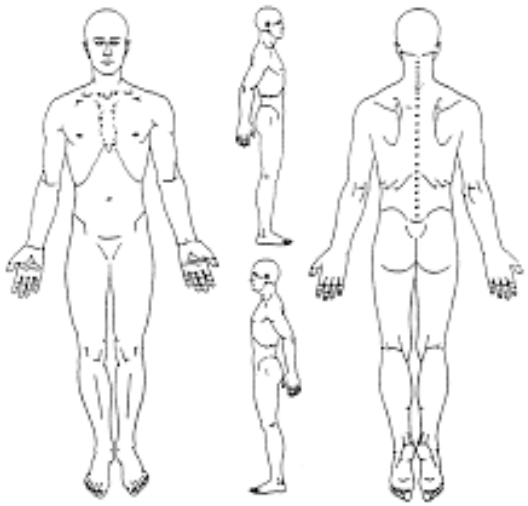
Health History

Height: Weight:

Primary concerns and complaints:

_____
_____
_____
_____

On the following drawing indicate the areas you feel should be addressed



Do you have any contagious disease at this time? (ie. Hepatitis, HIV, Flu, TB, etc.):

Are you currently pregnant:

Are you trying to get pregnant:

Family History (circle and add relation if applicable):

Cancer	Hypertension	Mental Illness
Diabetes	Stroke	Tuberculosis
Heart Disease	Epilepsy	Other

Past Medical History (Surgery, Hospitalization, And Serious Illness):

Allergies (medications, herbs, food, other):

Current Medication you are taking:

Food Cravings or Dislikes: (Sweets, Salts, Fried foods)

Digestive Disturbances:

Alcohol, Tobacco, Recreation Drug Use:

Current Problems Emotional	Thirst Y N	Sore Throat Y N
Problems Y N	Sinus Problems Y N	Constipation Y N
Night Sweats Y N	Thyroid Disorder Y N	Swollen Glands Y N
Mood swings Y N	Painful Urination, Burning, Blood	Fainting Y N
Easy Perspiration Y N	Y N	Cough Y N
Depression Y N	Memory Problems Y N	Nausea Y N
Headaches Y N	Urinary Incontinence Y N	Shortness of Breath Y N
Anxiety, Nervousness Y N	Dizziness Y N	Back Pain Y N
Hearing Loss Y N	High/Low Blood Pressure Y N	Edema Y N
Stress, Tension Y N	Chills/Fever Y N	Joint Pain/Aches Y N
Ears Ringing, Ache Y N	Angina or Chest Pain Y N	Blood in Stools Y N
Fatigue/Insomnia Y N	Skin Problems Y N	Easy Bleeding/Bruising Y N
Eye pain, Strain, Blurring, Dry	Abdominal Pain/Cramps,	Hemorrhoids Y N
Eyes, Tearing Y N	Digestive Disorder Y N	Spasms Y N
Diabetes Y N	Lumps Y N	Low Back Pain Y N
Frequent Colds/Flu Y N	Diarrhea/ Loose Stools Y N	

FOR MALES ONLY

Testicular Pain Y N	Impotence Y N
STD Y N Diagnosis:	Prostate Problems Y N

FOR FEMALES ONLY

Age of First Menses:	Regular Cycles Y N	Menopausal Problems Y N
Length of Cycle (Days):	Pregnant Y N	Bleeding/Spotting Between
Duration of Menses:	Vaginal Discharge Y N	Cycles
Painful Menses Y N	Number of Pregnancies:	Breast Lumps Y N
Heavy Flow Y N	Problems in Pregnancy Y N	Problems in Delivery Y N
PMS Y N	Birth Control Y N	STD Y N diagnosis:

Any other information you may wish to add:

Thank you for taking the time to complete this questionnaire. Please feel free to ask any questions you may have.

Protection of Privacy: The personal information requested on this form is collected and protected under the authority of Part 2 of the Alberta Freedom of Information and Protection of Privacy Act. It will be used for the purpose of patient intake and assessment only.