Lisa Gallant RA.c, Halifax Yoga, 902.406.9642, info@halifaxyoga.com

Acupuncture and Traditional Chinese Medicine

Intake Form

Please fill out this questionnaire to ensure the best possible care. All information is kept confidential. Please ask if you need assistance. Thank you[1]

Name: _____Date: _____

Address: _____

Email: _____Home Phone: _____

Work Phone: _____

Age: _____ Date of Birth: _____ Sex M/F:____

Occupation:_____Employer:_____

Emergency Contact:_____Phone:_____

Physician: _____ Phone:_____

Have you received acupuncture therapy before? Y / N (date)_____

How did you hear about my services?_____

Main problem/s you would like help with

1. _____
2. _____
3. _____

When did the problem(s) begin?

Have you been given a diagnosis for the problem(s)? If so, what?

What kind of treatments have you tried?

Daily living

Please indicate usage per day or per week:
Water _____ glasses per day
Coffee _____ cups per day/week (circle)
Tea _____ cups per day/week (circle)
Alcohol _____ day/week Type liquor/beer/wine
Soft Drinks _____ day/week
Cigarettes _____ day/week
Sweets _____ day/week

_____

Diet and exercise

Please describe your general diet:

Breakfast:

Lunch:

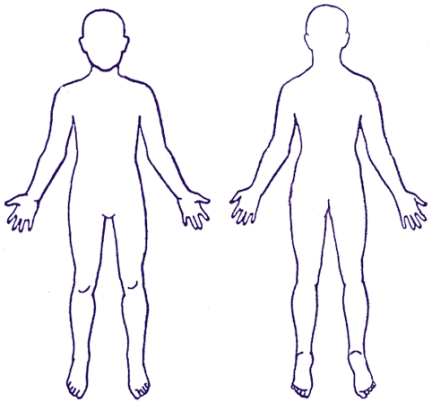
Dinner:

Snacks:

Please indicate how many times you exercise per week, and briefly describe your typical routine:

Muscles/ Bones/ Joints

Do you have pain or tightness? No / Yes. If Yes, please indicate the location on the chart below.



Rate your pain on a scale from 1 to 10

No pain 1 2 3 4 5 6 7 8 9 10 ***Extreme pain***

Circle the quality that best describes your pain:

Sharp
Dull
Aching Numb
Burning and/or Tingling
Pain worse in am/pm
Pain worse/better with heat
Pain worse/better with cold
Pain worse/better with pressure

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Medical History (Check all that apply):

Please list any past surgeries, and date:

Do you have a pacemaker? Yes/ No

Please list medications you are currently taking:

Please check any of the following that apply to you, past and present:

__Allergies __Hemophiliac __HIV/ Hepatitis __Anemia __Arteriosclerosis __Asthma __Anorexia __Bleeding Disorders __Bronchitis __Bulimia __Cancer __Candidiasis __Chronic Fatigue __Convulsions __Depression __Diabetes __Eczema __Emphysema __Epilepsy __Gout __Heart disease __Hernia __Herpes simplex 1 __Herpes simplex 2 __High blood pressure __High cholesterol	__Hyperglycemia __Hypoglycemia __Inflammatory Bowel Disease __Jaundice __Kidney disorders __Liver disorders __Low Blood Pressure __Lupus __Menstrual Disorders __Multiple Sclerosis __Osteoarthritis __Parkinson's __Pneumonia __Polio __Prostate Disorders __Psoriasis __Psychiatric Care __Rheumatoid Arthritis __Seizures __Stomach Ulcers __Stroke __Thyroid Disorders __Tonsillitis __Tuberculosis __Urinary Tract Infections __Venereal Disease Other_____

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Please write "C" for current or "P" for past in front of conditions that applies to you:

Gastrointestinal	***Urinary/ Genital***
__Nausea/ vomit	__Painful/itching genitals
__Heartburn	__Painful urination
__Ulcer	__Excessive urination
__Hiccups	__Urgent urine
__Diarrhea	__Blood in urine
__Constipation	__Incontinence of urine
__Gas and bloating	__Wakes at night to urinate
__Abdominal pain	__Kidney/bladder stones
__Loose stool	
__Dry stool	
__Blood in stool	
__Mucus in stool	
__Itching/burning anus	

Respiratory	**Cardiovascular/ Circulatory**
__Chronic cough	__Palpitations
__Weak cough	__Chest pain
__Load cough	__Irregular heart beat
__Cough up white phlegm	__Chest pain
__Cough up yellow phlegm	__High blood pressure
__Cough up blood	__Low blood pressure
__Shortness of breath	__Cold hands and feet
__Asthma/ Wheezing	__Excessive bleeding
__Frequent colds	

Head/ Neck/ Face	**Emotions**
__Dizziness/light headed	__Fearful
__Headache/migraine	__Sadness
__Faint	__Grief
__Neck stiffness	__Anger/frustration
__Jaw pain	__Over worry
__Facial tics	__Anxious
__Facial paralysis	__Forgetfulness

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Muscle/ Joint	**Eyes**
__Joint pain	__Poor vision
__Body ache and stiffness	__Blurry vision
__Numbness/tingling	__Floaters
__Heavy body	__Dry eyes
__Knee pain	__Watery Eyes
__Low back pain	__Red/itchy eyes

Skin	**Nose/Throat/Mouth**
__Hives/rashes	__Sinus infections
__Eczema/psoriasis	__Allergies
__Acne	__Recurring sore throat
__Night sweats	__TMJ
__Spontaneous sweats	__Excessive thirst
__No sweat	__Lack of thirst
__Dry skin	__Mouth ulcers
__Bruise easily	__Teeth pain
__Brittle/dry nails	__Prefer warm drinks
	__Prefer cold drinks

General	**Men's Health**
__Insomnia	__Impotence
__Excessive sleep	__Infertility
__Fatigue	__Seminal emissions
__Dizziness	__Premature ejaculation
__Numbness	__Decreased libido
__Frequent chills	
__Fever	
__Premature hair loss	
__Premature greying	
__Edema	

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Women's Health:

Menstruation:
How many days are between your period?_____
Please indicate if you have experienced any of the following between your period:
__ Yellow vaginal discharge __ Cramps or pain. If yes, **when**? before/ during/ after
__ White or clear discharge __ Spotting or bleeding between periods

How many days in duration is your period?_____
Please indicate the quality/ quantity of blood:
__ Light red __ Heavy flow
__ Dark red __ Normal flow
__ Clotted __ Scanty flow

Do you experience breast tenderness? If yes, when? Where?

Pregnancy:
How many pregnancies have you had?_____
Indicate any pregnancy-related difficulties?_____
Have you had any miscarriages? Yes/ No
Are you currently pregnant? Yes/ No
Are you trying to become pregnant? Yes/ No
Are you using contraceptives? Yes/ No

Menopause:
Please indicate your current status:
__Premenopausal __Perimenopausal __Postmenopausal

At what age did menopause begin?
Please indicate symptoms that apply to you?

*** 24 hours of notice is needed for cancellations. There will be a charge of $25.00 for missed appointments without cancellation. Herbal products are non-refundable after they are opened.**

Patient Signature:_____

Guardian Signature:_____
(If patient is under the age of 16)

Date:_____

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