ADVANCED HEALING CENTRE

ACUPUNCTURE | CHINESE MEDICINE

1325 Eglinton Ave. East Unit 220, Mississauga, Ontario L4w 4L9

(905) 272- 4325 www.advancedhealingcentre.ca

Welcome to **ADVANCED HEALING CENTRE**

THANK YOU for choosing us. We understand that you may have found us today through a friend or family member, an online search, or a local community event.

The best outcomes with acupuncture and Chinese medicine are possible when the practitioner has a complete understanding of your health history and your physical, mental and emotional symptoms. Please complete our confidential New Patient Intake Form as thoroughly as possible. If you have questions, please ask.

We will begin today with a consultation first to discuss your health history, your current health concerns, and the purpose of your visit. Following your in-depth consultation today, we may complete an examination, and possibly your first treatment.

Thank you!

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New Patient Intake Form **Today's Date:**

Note: Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Personal Health History						
Name:				Home Phone:		
Address:				Cell Phone:		
City:				Business Phone:		
Province:		Postal Code:		E-mail:		
Date of Birth:	M	D	Y	Age:	Sex:	Weight:
Circle One: *Single Married Widowed Divorced*				Spouse's Name:		
Names and Ages of Children:						
Employer:				Type of Work:		
Emergency Contact:				Emergency Contact Number:		
How did you hear about us?						
☐ Yes, I would like to receive emails, including insurance receipts, newsletters, appointment reminders						☐ No emails ever.

Is this your first experience with acupuncture or Chinese Medicine?		☐ Yes	☐ No
(Women only)	Are you currently pregnant?	☐ Yes	☐ No
	Are you presently trying to get pregnant?	☐ Yes	☐ No

Main complaint	Intensity	
If you could get rid of any health problems what would you want to get rid of. (Please list in the order of importance below), and we will let you know if we can help.	On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = no discomfort,10 = extreme discomfort)	
1).	on **AVERAGE** your complaint is	at **WORST** your complaint is:
2).	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3).	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4).	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5).	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
6).	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Onset		What have you tried doing to resolve these problems that DID NOT work?
For each condition listed above, please mark when it first began, or when you started experiencing them?		When it first began, or when you started experiencing them? The definition of "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or the treatment did not restore your body's own ability heal itself.
1).	Date began:	
2).	Date began:	
3).	Date began:	
4).	Date began:	
5).	Date began:	
6).	Date began:	

Frequency		Duration
Please check the box that best represents how frequent you feel your chief complaint(s):		When you are feeling your symptoms, how long do your symptoms last?
1).	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
2).	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
3).	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
4).	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
5).	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
6).	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant

What Aggravates or Alleviates your Chief Complaints?		
What **AGGRAVATES** each of the complaints above?		What **ALLEVIATES** each of the complaints above?
1).		
2).		
3).		
4).		
5).		
6).		
How are your health problems interfering with the following areas of your life?		
Work		
family		
Hobbies		
Life		

Previous Health Professionals

Previously, I have been treated by: (check all that apply)	How long did you receive treatment?			Helped Symptoms	Some Difference	No Help or Change
☐ Acupuncturist	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Chiropractor	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Massage Therapist	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Physiotherapist	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Naturopathic Doctor	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Nutritionist/Dietician	☐ Weeks	☐ Months	☐ Years	☐	☐	☐
☐ Other: ____________________	☐ Weeks	☐ Months	☐ Years	☐	☐	☐

How have you taken care of your health in the past?

Medications Surgery Injections Exercise Dietary Modifications Vitamins & Supplements

Acupuncture Chinese Herbal Medicine Chiropractic Arrosti / Active Release Therapy Massage

Other: ____

How did the previous methods work for you? ____

____

ARE YOU HERE VISITING US, BECAUSE YOU: (please choose one)

a) Just want to get some Relief from your symptoms, and then you'll manage the rest with medication

b) Want to Find & Correct the Root Cause of your Health problem(s), if possible, and Start a Lifestyle program for optimized living where your body can heal itself without medications or be less dependent upon medications.

c) Other: ____

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy

with your progress? (Please take your time and don't sell yourself short!)
____
____
____
____

What is your daily/weekly intake of the following: Caffeine _______________ Alcohol _______________ Nicotine/Tobacco _______________

Illicit Drugs: ❑ Yes ❑ No Comments ____

List ALL Medications (prescription & over-the-counter) you are CURRENTLY taking (include duration of use & Dosage):
____
____

List ALL Nutritional Supplements, Herbs, or vitamins you are currently taking:
____
____

Family Medical History

Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis, etc.

Father:	Mother:
Brothers:	Sisters:
Grandfathers:	Grandmothers:

Medical History

☐ HIV	☐ Fibromyalgia	☐ Asthma
☐ Hepatitis A B C	☐ Heart Disease	☐ Emphysema
☐ Tuberculosis	☐ Pacemaker	☐ Diabetes Type 1 Type 2
☐ Mumps	☐ Multiple Sclerosis	☐ Epilepsy/Seizures Disorder
☐ Measles	☐ Lupus	☐ Thyroid Disorder
☐ Chicken Pox/Shingles	☐ Joint Replacements	☐ Eating Disorder
☐ Herpes _______________________	☐ Rheumatoid Arthritis	☐ Autoimmune Disease:______________
☐ Sexually Transmitted Disease	☐ Osteo-Arthritis	☐ Cancer: _________________________
☐ Polio/Rheumatic Fever/Scarlet Fever	☐ Osteoporosis	__________________________________
☐ Lyme Disease	☐ Anemia	__________________________________

Allergies

☐ Peanuts/nuts	☐ Shellfish	☐ Dust	☐ _______________________
☐ Milk/Dairy	☐ Soy	☐ Cats/Dogs/Animals	☐ _______________________
☐ Egg	☐ Gluten/Wheat	☐ Pollen	☐ _______________________

Surgeries (and approximate year)

☐ Gallbladder removed	_____________	☐ Dental Surgery	_____________
☐ Appendix removed	_____________	☐ Heart surgery	_____________
☐ Hysterectomy	_____________	☐ Knee surgery	_____________
☐ Tonsils removed	_____________	☐ ______________________	_____________

Exercise & Energy

How is your energy?	☐ Exhausted ☐ Low ☐ Below Normal for me ☐ Average ☐ Good/High
What time of day is your energy: Highest?	☐ Mornings ☐ Noon ☐ Afternoon ☐ Early Evening ☐ Evening/Night
What time of day is your energy: Lowest?	☐ Mornings ☐ Noon ☐ Afternoon ☐ Early Evening ☐ Evening/Night
Do you fatigue easily?	☐ Yes ☐ No
How often do you exercise?	Do you exercise: ❑ Never ❑ Daily ❑ Weekly ❑ Monthly Explain:____________
What kind of exercise do you do regularly?	
Do your work activities mostly involve:	❑ Sitting (time:) ❑ Standing (time:) ❑ Light Labor ❑ Heavy Labor

We find that when all of your healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here? ❑ yes ❑ no

IMPORTANT: Complete these documents as thoroughly as possible, please be honest with yourself. Some of the questions that follow may seem unrelated to your condition, BUT they may play a major role in diagnosis and treatment. **All information is strictly confidential**.

Please check all symptoms that you experience either ACUTELY or CHRONICALLY

LUNG System Function (Large Intestine, Thyroid, Thymus)

❑ Shortness of Breath
❑ Wheezing / Difficulty Breathing / Heaviness in chest / Asthma
❑ Easily catch colds / Chronic Infections
❑ Nasal / Sinus Problems
❑ Nose Bleeds
❑ Cough (dry / productive / blood / persistent)
❑ Snoring
❑ Loss of Smell / Taste
❑ Dry Nose / Mouth
❑ Dry / Sore Throat
❑ Dry Skin
❑ Allergies, Sneezing
❑ Alternating fever & chills
❑ Excessive Sweating
❑ Difficult Sweating
❑ Headaches
❑ Stiff Neck & Shoulders
❑ Chronic sadness
❑ Constipation / Difficult Defecation
❑ hemorrhoids / Blood / Mucous in Stools

SPLEEN System Function (Stomach, Pancreas)

❑ Low appetite
❑ fatigue after eating
❑ Loose stools / Diarrhea
❑ undigested food in stool
❑ Abrupt Weight Gain
❑ Abrupt Weight Loss
❑ Abdominal Bloating / Gas
❑ Gurgling noise in stomach
❑ Bleeding, swollen/painful gums
❑ Heartburn / Acid Regurgitation
❑ Nausea / Vomiting
❑ Frequent Belching / hiccups
❑ Frequent / Constant Hunger
❑ Stomach pain
❑ Bad breath
❑ Canker sores in the mouth
❑ Bruise easily
❑ Always worrying / over-thinking everything
❑ Weak / Atrophy in muscles
❑ whole body feels heavy
❑ Fluid retention (edema, heavy limbs & body) ❑ Swollen feet / Legs / Joints

HEART System Function (Pituitary Gland, Small Intestine)

❑ Anxiety / Restlessness ❑ Sores on tip of Tongue, speech problems ❑ Trouble falling / Staying asleep ❑ waking up un-refreshed, tired ❑ Frequent Dreams ❑ Mental Sluggishness / Fogginess ❑ Inability to focus (ADD, ADHD) ❑ Chest Pain traveling to shoulder ❑ Fast heart beat (>100 beats/min) ❑ Slow heart beat (<50 beats/min) ❑ Palpitations / Heart Fluttering ❑ Irregular heart beat

LIVER System Function (Gall Bladder, Pineal Gland)

❑ Alternating Diarrhea & Constipation
❑ Tight sensation in the chest
❑ Bitter taste in the mouth
❑ Irritable, Angry & frustrated frequently
❑ Mood Swings
❑ suffer from depression
❑ Skin Rashes (redness, itching)
❑ Headache at the top & sides of the Head, Migraines
❑ Numbness / Tingling Sensation
❑ Muscle Twitching / Cramping / Spasms
❑ Seizures / Convulsions, tremors, tics
❑ Lump in the throat
❑ Neck & Shoulder Tension / tightness / pain
❑ Joint Pain
❑ TMJ pain
❑ High-pitched ringing in ears
❑ Difficulty adapting to stress, teeth grinding
❑ Dizziness / poor balance / vertigo EYES/VISION
❑ Itchy Eyes
❑ Blood Shot Eyes
❑ Burning Eyes
❑ Dry Eyes
❑ Watery Eyes
❑ Gritty Eyes
❑ Blurry Vision
❑ Decreased Night Vision
❑ Floaters in the eyes

KIDNEY System Function (Urinary Bladder, Adrenal Glands)

❑ Cold Hands & Feet
❑ Feels cold all the time whole body
❑ Hot Flashes & Night Sweats
❑ Thirsty all the time
❑ Frequent cavities, teeth problems
❑ Sore Achy / Weak Knees
❑ Lower Back Pain
❑ Memory Problems (short term & long term)
❑ Excessive hair loss, premature greying of hair
❑ Low-pitched ringing in the ears
❑ Poor Hearing / Hearing problems URINATION
❑ Lack of bladder control (incontinence)
❑ Wake during the night >1 time to urinate?
❑ Scanty Urination
❑ Profuse Urination
❑ Frequent Urination
❑ Urgency to urinate
❑ Difficult / Incomplete urination
❑ Painful / Burning urination
❑ Cloudy Urine
❑ Reddish urine
❑ history of chronic fear
❑ Easily startled
❑ General Weakness, low energy, chronic fatigue
❑ Low or No Libido
❑ Excessively high libido FOR MEN ONLY
❑ swollen testes
❑ Testicular Pain
❑ Inability to maintain erection

	❏ Premature ejaculation

Emotions & Sleep

How do you feel emotionally?	☐ Balanced ☐ Unbalanced ☐ Sometimes balanced/unbalanced
How do you hold/handle your stress?	☐ Very Well ☐ Ok ☐ Not Well
How do you feel generally about your life?	☐ Positive ☐ Neutral ☐ Negative ☐ Sometimes +/-
How long do you normally sleep?	☐ Less than 4 hrs ☐ 4-6 hrs ☐ 6-7 hrs ☐ 7-9 hrs ☐ 9 hrs or more

Do you have: (check all that apply)

☐ Panic attacks	☐ Depression	☐ Anxiety	☐ Irritability
☐ Bad temper	☐ Mood Swings	☐ Poor memory	☐ Difficult concentration

Do you have difficulties with: (check all that apply)

☐ Falling asleep	☐ Staying asleep	☐ Dream-disturbed sleep	☐ Nightmares
☐ Waking up at night	☐ Waking up multiple times	☐ Can't fall back asleep	☐ Wake up not rested

Food & Drink Preferences

Do you have: (check all that apply)

☐ Prefer cold drinks	☐ Usually drink in small sips	☐ Feel Hungry often	☐ Prefer/crave sour
☐ Prefer hot drinks	☐ Usually drink in big gulps	☐ Feel Thirsty often	☐ Prefer/crave bitter
☐ No drink preference	☐ Eat gluten free	☐ Drink green tea daily #____	☐ Prefer/crave spicy
☐ Eat vegan (no animal)	☐ Eat egg free	☐ Drink coffee daily #____	☐ Prefer/crave sweets
☐ Eat vegetarian + eggs/dairy	☐ Eat dairy free	☐ Drink water daily #____	☐ Prefer/crave salts
☐ Eat meat, dairy, eggs, fish	☐ Eat low sodium	☐ Eat deep fried foods	☐ Eat 4+ vegetables daily
☐ Eat paleo/keto/low carbs	☐ Eat/drink processed sugar	☐ Eat at fast food places	☐ Eat 2+ fruit daily
☐ Usually skip breakfast	☐ Eat/drink processed foods	☐ Cook all meals at home	☐ Take a multivitamin

Smoking, Alcohol & Drugs

Do you smoke? ☐ Yes ☐ No ☐ I used to
How many cigarettes/day now? ________
How many years? ________
Do you drink alcohol? ☐ Yes ☐ No ☐ I used to
Do you use recreational drugs? ☐ Yes ☐ No ☐ I used to
Which drugs used in the last year?

Do you want to quit smoking? ☐ Yes ☐ No
When did you start? (age/year) ________
When did you quit? (age/year) ________
How many drinks per week now? ________
Do you want to quit using alcohol or drugs? ☐ Yes ☐ No

Gastrointestinal Symptoms

Do you have: (check all that apply)

☐ Belching	☐ Nausea	☐ Vomiting	☐ Vomiting of blood
☐ Ulcers	☐ Bloating	☐ Heartburn/acid reflux	☐ Crohn's/Celiac Disease
☐ Hernia	☐ Indigestion	☐ Severe Abdominal pain	☐ Intestinal sounds
☐ Gall stones	☐ Fatty Liver	☐ Mild abdominal soreness	☐ Gastritis

Bowel Movements

How often do you have a bowel movement? / day or / week

Do you have: (check all that apply)

☐ Constipation	☐ Diarrhea	☐ Gas	☐ Irregular bowel movements
☐ Burning sensation	☐ Hemorrhoids	☐ Itchiness after BM	☐ Undigested food in stool
☐ Loose stools	☐ Hard stools	☐ Blood in stool	☐ Painful bowel movements
☐ Very smelly stools	☐ White mucus in stools	☐ Abdominal cramping	☐ IBS/Colitis/Diverticulitis

Urinary Symptoms

How often do you urinate? / day

Quality/Colour of Urine: ☐ Pale yellow ☐ Dark yellow/orange ☐ Bubbles ☐ Cloudy

Do you have: (check all that apply)

☐ Trouble starting stream	☐ Frequent urination	☐ Blood in urine	☐ Urinary tract infections
☐ Pain urinating	☐ Burning	☐ Dribbling urine	☐ White/yellow mucus in urine
☐ Kidney stones	☐ Occasional Incontinence	☐ Incontinence	☐ Kidney disease

Muscles, Joints & Bones

Do you have: (check all that apply)

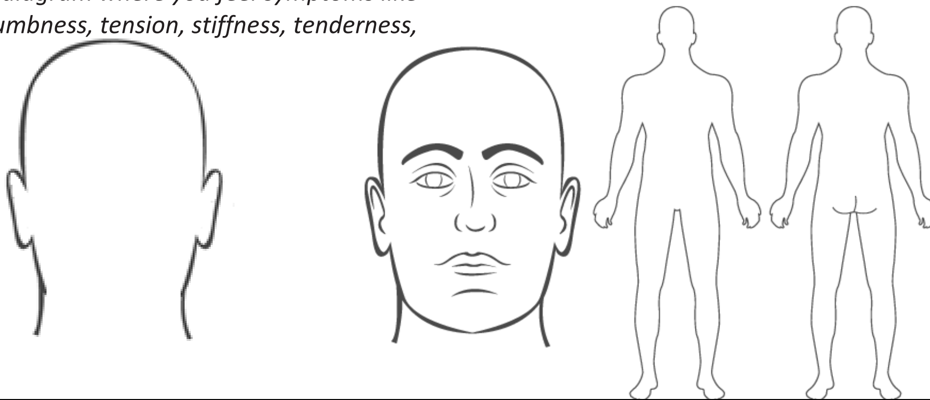
☐ Swollen joints
☐ Stiff joints
☐ Bone pain
☐ Arthritis/Joint pain
☐ Muscle pain
☐ Muscle tension
☐ Muscle cramps
☐ Restless Leg Syndrome
☐ Tendonitis
☐ Fibromyalgia
☐ Repetitive Strain Injury
☐ Fractured Bone:___________________

Describe the pain/tension: (check all that apply)

☐ Sharp
☐ Numbness
☐ Aching
☐ Dull
☐ Tingling
☐ Stabbing
☐ Superficial
☐ Burning
☐ Shooting
☐ Deep
☐ Squeezing
☐ ________________________

Applying heat make the symptom: ☐ Better ☐ Worse ☐ No difference
Applying cold/ice makes the symptom: ☐ Better ☐ Worse ☐ No difference
Applying pressure makes the symptom: ☐ Better ☐ Worse ☐ No difference

Please mark on the diagram where you feel symptoms like headaches, pain, numbness, tension, stiffness, tenderness, tightness, etc.:



Head & Face

☐ Headaches: ☐ Migraine ☐ Tension ☐ Cluster ☐ Hormonal ☐ Sinus
☐ Concussion ☐ Numbness ☐ Paralysis ☐ Bell's Palsy

Where do you feel the headaches? ☐ Front/forehead ☐ Top of head ☐ Sides/Temples ☐ Back/occipital/neck ☐ Behind eye(s)

How often do you get a headache? ☐ 1-2/year ☐ 3-11/year ☐ 1/month ☐ 2-4/month ☐ 1-2/week ☐ More than 2/week

How long does a bad headache last without medication? ☐ Minutes ☐ 1-4 Hours ☐ 4-12 hours ☐ 12-24 hours ☐ Days

Ever had a concussion? ☐ Yes ☐ No How many? _________ Still have any post-concussion symptoms? ☐ Yes
Ever had a whiplash? ☐ Yes ☐ No How many? _________ Still have any chronic whiplash symptoms? ☐ Yes

Ears, Nose, Throat

Do you have: (check all that apply)

☐ Frequent colds/flu
☐ Chronic cough
☐ Difficulty/pain on inhaling
☐ Difficulty/pain exhaling
☐ Dizziness
☐ Painful/red nose/throat
☐ Clogged/popping in ears
☐ Chronic runny nose
☐ Coughing blood
☐ Asthma
☐ Chronic sinus infections
☐ Cold sores
☐ Ear pain
☐ Jaw/TMJ pain
☐ Frequent sore throat
☐ Cough up mucous
☐ Nose bleeds
☐ Current Sinus infection
☐ Bleeding gums
☐ Ringing in ears
☐ Dry mouth/sinuses

Eyes

Do you have: (check all that apply)

☐ Dry eyes
☐ Red/itchy eyes
☐ Blurry vision (near or far)
☐ Eye fatigue / strain
☐ Night myopia
☐ Reading glasses/bifocals
☐ Current eye infection
☐ Chronic eye infections
☐ Reading glasses/bifocals
☐ Cataracts
☐ Glaucoma
☐ ___________________________

Skin & Hair

Do you have: (check all that apply)

☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Bruise easily
☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature greying
☐ Oily skin ☐ Facial pimples ☐ Facial acne ☐ Body acne

Temperature/Sensation

Do you have: (check all that apply)

☐ Feel cold all the time ☐ Feel cold often ☐ Cold feet or hands ☐ Dislike dry air
☐ Feel hot all the time ☐ Feel hot often ☐ Hot feet or hands at night ☐ Dislike humidity
☐ Feel better in cold weather ☐ Feel better in hot weather ☐ Feel better in dry weather ☐ Feel better in humid weather
☐ Feel worse in cold weather ☐ Feel worse in hot weather ☐ Feel worse in dry weather ☐ Feel worse in humid weather
☐ Feel worse in winter ☐ Feel worse in summer ☐ Feel worse in spring ☐ Feel worse in autumn
☐ Dislike wind ☐ Dislike cold weather ☐ Dislike hot weather

Men Only

Do you have: (check all that apply)

☐ Enlarged Prostate issues ☐ Erectile dysfunction ☐ Low motility sperm ☐ Testicular/Prostate Cancer
☐ Night sweats ☐ Loss of morning erection ☐ Low sperm count ☐ Mood swings/angry outbursts
☐ Profuse sweating

Women Only

Do you have: (check all that apply)

☐ Menstrual cramps/pain ☐ Late/missed periods ☐ Early/frequent periods ☐ Mid-cycle spotting
☐ PCOS/Ovarian Cysts ☐ Vaginal itching/discharge ☐ PMS symptoms ☐ PMS/Menopause headaches
☐ Uterine fibroids ☐ Vaginal dryness ☐ Day sweats ☐ Breast problem
☐ Menopausal symptoms ☐ Hot flashes ☐ Night sweats ☐ Breast cancer
☐ Hysterectomy ☐ Endometriosis ☐ Recurrent yeast infection ☐ Ovarian/Cervical/Uterine cancer
☐ Tender breasts ☐ Fibrocystic breasts ☐ Pain during sex

Menstruation: (check all that apply)

Blood colours: ☐ dark red ☐ bright red ☐ pale/pink ☐ blackish ☐ purple ☐ brown
Clot: ☐ no clots ☐ some small clots ☐ some large clots ☐ dark clots ☐ red clots ☐ dilute/watery
Flow: ☐ heavy ☐ very heavy ☐ very light ☐ light
Days of flow: ☐ none ☐ 1-3 days ☐ 4-6 days ☐ 7 or more days

Menstrual Pain: ☐ before flow ☐ first day ☐ during period, any day ☐ after period ☐ on ovulation

Reproductive history:

Menstruation started at age: ________________________ Menstruation ended at age: ________________________
☐ Children # _________ ☐ Pregnancies # _________ ☐ Abortions # _________ ☐ Miscarriages # _________

Fertility:

☐ I am trying to conceive ☐ I am not trying to get pregnant but could become pregnant during the course of treatment.

Gynecological Exams:

❖ Sonogram of your reproductive organs? □Yes □No
Results? ____
❖ Cervical Biopsy? □Yes □No
Results? ____
❖ Hysterosalpingogram (HSG) – results: □Positive □Negative
❖ Hormonal Tests:
- ♣ FSH .... □Normal □High □Low
- ♣ Estrogen, E2 .... □Normal □High □Low
- ♣ Progesterone .... □Normal □High □Low
- ♣ Prolactin .... □Normal □High □Low
- ♣ Thyroid .... □Normal □High □Low
- ♣ Testosterone .... □Normal □High □Low

Previous Gynecological Surgeries:

Oral Contraceptives:

Have you take oral contraceptives before? .... □Yes □No
If yes, for how long? _______________________________
When did you stop? _______________________________
Have you ever had an IUD?..□Yes □No
What type of IUD? _______________________________

Number of:	List the dates:
Pregnancies	
Cesarean	
Births Vaginal Births	
Abortions Miscarriages	
Failed IUI's Failed IVF's	
Bladder infections / year	
Yeast infections / year	

Spouse Information:

□Dilation & Curettage (D&C)

□Laparoscopy (endometriosis / cysts / fibroids)

□Hysteroscopy (results: _______________________________________)

Fertility Medications taken within last year:

Date	Medication

Have you ever been diagnosed with:

STDs.. □Yes □No
Pelvic Inflammatory Disease............... □Yes □No
Uterine Fibroids .... □Yes □No
Polyps.. □Yes □No
Pelvic Adhesions .... □Yes □No
Prolapsed Uterus .... □Yes □No
Abnormal shape of Uterus .... □Yes □No
Endometriosis. .... □Yes □No
PCOS .... □Yes □No

Spouse's Name: ____
Spouse's Age: ______ Spouse's Occupation: ____________________ Has your spouse fathered other children? ________________________

Menstrual Cycle: What age did you start your 1 st period: _________
Typical Menstrual Cycle length (ex: 26-30 days): _________
How many days do you typically bleed (do not count spotting)? _________ Date of last Menses: _________________

OVULATION:

- ❖ Do you take medications to help you ovulate? ....□Yes □No
  If yes, what kind? ____
  For how many cycles? ______________________________________
- ❖ Do you chart your cycle? (circle) BBTs / OPKs / Saliva

Additional Information

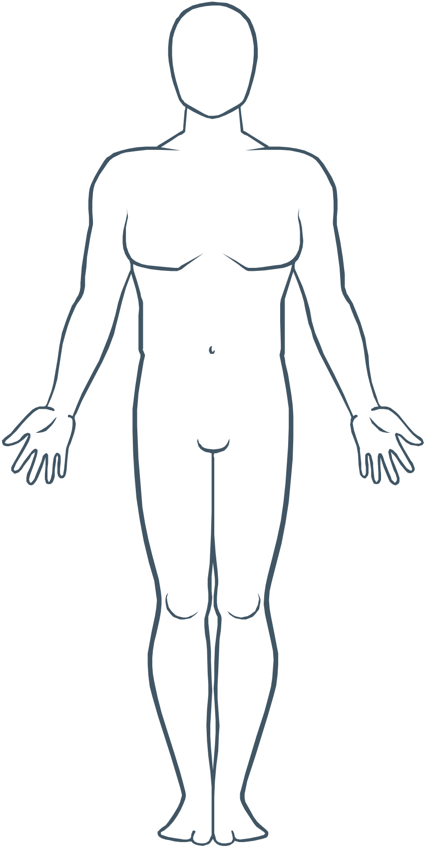
Please add anything else you would like to tell us about your health history that you feel is relevant and helpful to your diagnosis:

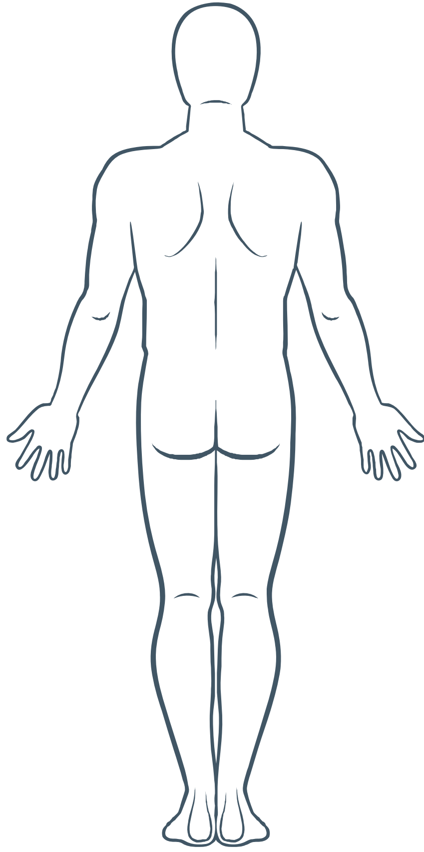
Current Health Professionals

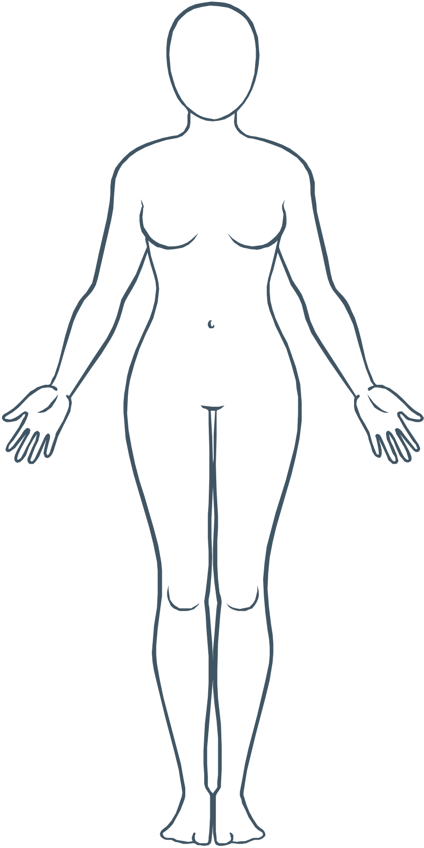
I am currently seeing: (check all that apply)

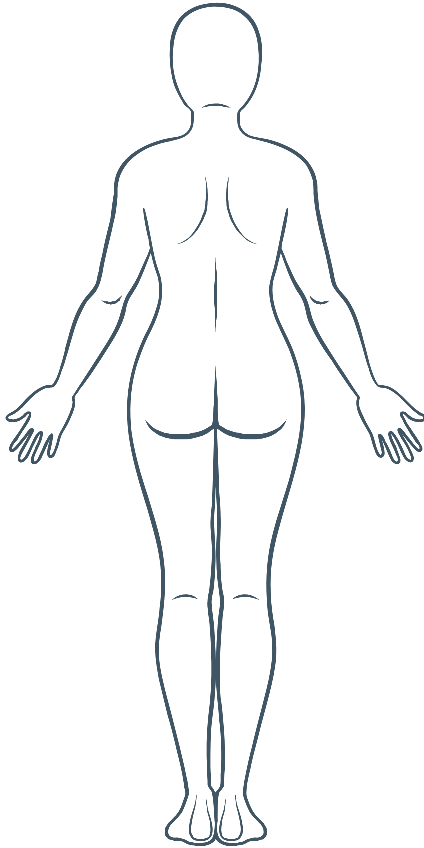
☐ Family Medical Doctor	Name:	Clinic:
☐ Chiropractor	Name:	Clinic:
☐ Massage Therapist	Name:	Clinic:
☐ Physiotherapist	Name:	Clinic:
☐ Naturopathic Doctor	Name:	Clinic:
☐ Dentist	Name:	Clinic:
☐ Acupuncturist	Name:	Clinic:
☐ Personal Trainer	Name:	Gym:
☐ Other: ___________________	Name:	Clinic:

Where do you feel ALL your symptoms you would like help with?









Patient Informed Consent to Acupuncture Assessment & Treatment Form

I hereby request and voluntarily consent to be treated with acupuncture, herbs, nutrition and/or other modalities (cold laser, phototherapy, electro-acupuncture, cupping, bloodletting, motor points, shiatsu, guasha, tuina, shiatsu, acupressure, as necessary) by the acupuncturist.

I understand that acupuncture is performed by the insertion of tiny needles through the skin at specific acupoints to restore normal physiological functions, to modify, reduce or prevent pain, to reduce symptoms and to balance the body toward an optimal state of homeostasis.

I have been made aware that, although not likely, certain risks or side effects to treatment. These include some local bruising, minor bleeding, temporary discomfort, possible aggravation of symptoms, minor pain or soreness, infection, stuck or bent needles, and extremely rare side effects including shock, convulsions, fainting, possible perforation of internal organs or blood vessels.

I have been advised that only pre-sterilized, single-use disposable needles will be used. All needles are properly disposed of after each treatment and are never re-used.

In understand that acupuncture has been practiced safely for many centuries. I also understand that results are not guaranteed. I wish to rely on the acupuncturists to exercise judgment during the course of treatment, which she/he feels is in my best interest.

FEMALE PATIENTS: I understand that I must notify the acupuncturist of any pregnancy before any treatment. I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that:

____I am pregnant ____ I am not pregnant, nor is there any possibility that I may be pregnant ____ I am trying to get pregnant.

CANCELLATION POLICY: Patients must provide 24-hour notice of cancellation, with the exception of an emergency. We charge a fee every time a patient does not provide at least 24-hours notice (by voicemail or email) to change an appointment. We charge the full treatment fee for any no-show appointment, where a patient has not provided any notice and does not show up for their appointment.

ARRIVAL & LATE POLICY: Please arrive at least 10 minutes before your scheduled appointment time. Please call the office if you are ever running late for your appointment. We will try our best to accommodate you; however, most of the time your appointment will be shorter in length and you will be charged the full appointment fee.

I have carefully read and I understand all the fore-stated and am fully aware of what I am consenting to.

PLEASE **READ BEFORE SIGNING.**

______________________________ ________________________ ______________________________

Signature Patient / Parent / Guardian Date Print Name

____

Acupuncturist Signature