



ACUPUNCTURE INTAKE FORM

Thank you for taking the time to complete the following new patient forms. Given this form is extensive, it plays an integral role in achieving our mutual goal of your optimal health.

Name			Date
Birth Date d d / m m / y y y y	Age	Gender	Home #
Address			
City	Province	Postal Code	
Phone number (preferred number used):		May we leave messages?	
Email Address:			
Occupation:			
Emergency Contact (Name and Relationship and Phone Number):			
Family Doctor – Name and Contact		Date of last physical:	
		Date of last blood work:	
How did you hear about Dr. Hillary?			

Please provide the reason you are seeking acupuncture treatment:

Have you tried other conventional or alternative treatments? If so, what were they and what were the results?

Please list any medications and/or supplements you are currently taking (Include vitamins, herbs, natural products and pharmaceuticals as well as dosage and frequency:

Which of the following illnesses and conditions have you had (past and present)? Please check all that apply:

SKIN HAIR AND NAILS

- Acne
- Psoriasis
- Warts (genital of facial)
- Eczema
- Roseola
- Chicken Pox

HEAD, EARS, EYES, NOSE, THROAT

- Migraines
- Headaches
- Mononucleosis
- Frequent Colds
- Ear Infections
- Eye Infections
- Strep Throat
- Hay Fever
- Sinusitis
- Tonsillitis
- Mumps
- Malaria

PELVIC ISSUES

- Sexually Transmitted Infections
- Candida (Yeast)
- Infertility

ENDOCRINE

- Diabetes
- Hypothyroidism
- Hyperthyroidism

MENTAL, EMOTIONAL, GENERAL

- Depression
- Anxiety
- Chronic Fatigue
- Multiple Sclerosis
- Schizophrenia
- Eating Disorder
- Lupus
- HIV
- Bipolar Disorder
- Epilepsy
- Hyperactivity
- Joint Pain
- Arthritis/Rheumatoid/Osteo

CARDIOVASCULAR AND RESPIRATION

- Difficulty Breathing
- Heart Disease
- Whooping Cough
- Tuberculosis
- High Blood Pressure
- Heart Palpitations
- Heart Murmur
- Frequent Coughs
- Shortness of Breath
- Pneumonia
- Croup
- Stroke
- Rheumatic Fever

GASTROINTESTINAL

- Bloating
- Gas
- Liver Disease
- Stomach or intestinal Ulcers
- Prostatitis
- Hepatitis
- Gall Stones
- Pancreatitis
- Diverticulitis
- Kidney Disease
- Kidney Stones
- Irritable Bowel Syndrome
- Constipation
- Chrons' Disease
- Acid Reflux
- Hernia
- Hemorrhoids

OTHER

- Seizures/epilepsy
- Insomnia/sleep issues
- Anemia
- High/low blood pressure
- liver/gall bladder disease
- Chronic pain issues
- Cholesterol issues

Women's Health

Age of first menstrual period: ____ Duration of period? ____ Length of cycle? ____

When was your last menstrual period? ____ Are your cycles regular? ____ Painful menses? ____

How heavy is your bleeding? LIGHT NORMAL HEAVY

What color is your blood? LIGHT RED RED DARK RED PURPLE BROWN BLACK

Is there clotting? If yes, they are BIG CLOTS SMALL CLOTS

Do you bleed or spot in between periods? YES NO

Are you pregnant? YES NO If yes, how many weeks? ____ Whose care are you under? ____

Birth control Method: _____

Birth control Method in the past (include how long used): _____

Endometriosis? YES NO Cervical dysplasia? YES NO Ovarian cysts/fibroids? YES NO

Abnormal pap smear? YES NO How many children do you have? ____

How many pregnancies? ____ How many abortions? ____ How many miscarriages? ____

Do you get yeast infections regularly? YES NO

Have you ever had a venereal disease? YES NO

Have you ever had pelvic inflammatory disease? YES NO

Have you ever been diagnosed with any pelvic abnormalities? YES NO

Do you get premenstrual back pain? YES NO

Do your bowel movements become loose at the beginning of your period? YES NO

Please circle all that apply to you, in relation to your menstruation:

- | | | | |
|-------------------|--------------------------|-------------------|-------------------------|
| Heavy flow | Light flow | Clotting | Vaginal discharge |
| Vaginal dryness | Vaginal Itching | Vaginal Odor | Pain During intercourse |
| Abnormal Pap Test | Spotting between Periods | Breast Tenderness | Painful periods |
| Cramping | Cravings | Headaches | Bloating |
| Water retention | Irritability | Fatigue | Insomnia |
| Anxiety | Others: _____ | | |

Have you had a hysterectomy? YES NO

Men's Health

Please circle all that apply to you:

Prostate Problems	Swelling/lumps in testicles	Painful erection
Discharge from penis	Infertility	Difficulty maintaining/achieving Erection
Premature ejaculation	painful/difficult urination	

Are you currently sexually active? YES NO

If yes, what type of contraception do you use? _____

General TCM Health History

Please circle all that apply to you:

During the day do you feel: CHILLS FEVERED PERSPIRATION WHEN NOT ACTIVE

Do you prefer to drink: WARM/HOT FLUIDS COLD FLUIDS

Are you frequently thirsty: YES NO SOMETIMES

Appetite: POOR NORMAL GOOD VORACIOUS

After eating do you experience: BLOATING GAS ACID REFLUX CRAVINGS FOR SWEET/SALT

Bowel movements: CONSTIPATED DIARRHEA BOTH UNUSUAL ODOR MUCUS RUNNY
 DRY URGENCY TO GO FIRST THING IN THE MORNING

UNDIGESTED FOOD IN STOOL BLOOD IN STOOL

Urine: WAKE DURING THE NIGHT TO URINATE UNUSUAL COLOR UNUSUAL ODOUR
 MUCUS IN URINE BURNING SENSATION HIGH FREQUENCY URGENCY

Energy: OFTEN TIRED NORMAL ENERGY LEVELS BETTER THAN NORMAL

PHYSICAL WEAKNESS/FATIGUE MENTAL FATIGUE EASILY STARTLED

Pain: LOWER BACK/MID BACK/UPPER BACK KNEES SHOULDERS HANDS

LEGS FEET HEELS WHEN YOU WALK ARMS TENSION IN YOUR

SHOULDERS/NECK OTHER

** Please indicate if the pain is sharp, dull, achy, hot, cold, stabbing, shooting and moving

Headaches: YES NO Where in your head?

Respiratory: SHORTNESS OF BREATH FREQUENT COUGH OFFENSIVE BREATH

Hair/Teeth/Eyes: HAIR or TEETH LOSS PREMATURE GREYING CLENCH OR GRIND TEETH

DRY EYES BLURRY VISION FLOATERS STRAINED WHEN TIRED

Sleep: DIFFICULTY FALLING ASLEEP DIFFICULTY STAYING ASLEEP – If so what time do you wake?

DREAMS WAKING FEELING HOT/SWEATY FEEL ANXIOUS HEART PALPITATIONS

What is your 'go to' emotion in a stressful situation? ANGER FEAR SADNESS WORRY

SHOCK

Thank you for taking the time to fill this out – I look forward to meeting with you and with you to provide your mind and body with optimal health!