Dr. Hillary, ND

www.mardaloopwellness.com

ACUPUNCTURE INTAKE FORM - PRENATAL / LABOUR PREP / INDUCTION

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:

____

____

____

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

____

____

____

Pregnancy Information

Due date: __________ How many weeks pregnant are you? __________

Midwife/OB: ____

Where will you give birth? ____

Please list any health concerns related to pregnancy: ____

____

____

Have there been any complications with this pregnancy? _____________________________________

____

Surgeries and dates: ____

Traumas (falls, auto accidents, etc): ____

Allergies: ____

Review of Systems

Please circle all that apply within the last 6 months

ALWAYS WARM	SWEATS EASILY	CHILLS	COLD HANDS AND FEET
NIGHT SWEATS	POOR SLEEP	FATIGUE	LOW ENERGY (TIME OF DAY?)
BRUISE EASILY	WEIGHT GAIN	WEIGHT LOSS	ECZEMA
RASHES	ACNE	ITCHING	DRY SKIN
HAIR LOSS	HIVES	PSORIASIS	HIVES
EYE PAIN	BLURRED VISION	DENTAL PAIN	NOSE BLEEDS
NIGHT BLINDNESS	FACIAL PAIN	GRIND TEETH	FREQUENT SORE THROATS
SINUS PROBLEMS	EARACHES	JAW PAIN	SPOTS IN VISION
SORES ON LIPS/MOUTH	POST NASAL DRIP	POOR HEARING	RINGING IN EARS
DIZZINESS	HEADACHES (WHERE?)	HIGH BLOOD PRESSURE	
SHORTNESS OF BREATH	PALPITATIONS	SWEELING OF HANDS OR FEET	
TIGHTNESS IN CHEST	CHEST PAIN	FAINTING	
HEART ATTACK	BLOOD CLOTS	COUGH	WHEEZING
ASTHMA	PNEUMONIA	PAIN WITH DEEP BREATH	
LOW APPETITE	BLOATING	DIARRHEA	BLOOD IN STOOL

GAS	NAUSEA	LOOSE STOOL	HEMORRHOIDS
BAD BREATH	VOMITTING	CONSTIPATION	CHRONIC LAXATIVE USE
ACID REFLUX	ALTERNATING LOOSE STOOL/CONSTIPATION		
STRONG THIRST	REMIND SELF TO DRINK	# OF BOWEL MOVEMENTS PER DAY	
PAINFUL URINATION	DARK URINE	URGENCY TO URINATE	
INCONTINENCE	IMPOTENCE	FREQUENT URINATION	
GENITAL SORES	CLOUDY URINE	KIDNEY STONES	
SEIZURES	POOR COORDINATION	BAD TEMPER	SUICIDAL THOUGHTS
TREMORS	AREAS OF NUMBNESS	IRRITABLE	DIZZINESS
ANXIETY	DEPRESSION	LOSS OF BALANCE	
FEARFUL			

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

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

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 DREAMS
	DIFFICULTY STAYING ASLEEP – If so what time do you wake?
	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 working with you to provide your mind and body with optimal health!