the IV health centre

Acupuncture Intake Form

Today's Date _____

Name _____ Date of Birth (M/D/Y) _____

Address _____ City _____

Postal Code _____ Phone _____

Email _____ Occupation _____

Family Doctor _____ Phone _____

Emergency Contact _____ Phone _____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV health centre's specials and newsletter.

How did you hear about the IV? ○ IV Website ○ Instagram ○ Facebook ○ Radio
○ Google ○ Family / Friend ○ Special Event ○ Other: _____

How did you hear about your Practitioner? ○ Website ○ Instagram ○ Facebook
○ Family / Friend ○ Referral - If so, who referred you: _____

Other Health Care Providers

Name _____ Phone _____

Name _____ Phone _____

Health Information

List your health concerns (physical, emotional or psychological) in order of importance to you, and the date your symptoms began:

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

What do you believe is causing your most important health concern?

_____

_____

_____

Allergies and Sensitivities

List all allergies to medications, environment and food:

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____
4. _____ Reaction _____

Supplements and Medications

List all supplements you are currently taking:

Supplement	Daily Dose	How Long	Reason

List all medications you are currently taking:

Medication	Daily Dose	How Long	Reason

Are the medications well tolerated?

○ Yes ○ No If no, what are the adverse reactions?

Medication _____ Reaction _____

Medication _____ Reaction _____

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Medical History

List any condition that you have been diagnosed with:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Indicate if you have had any of the following diagnostic tests performed:

	Notable Finding		Notable Finding
Thyroid Panel ○ Yes / ○ No		Cholesterol ○ Yes / ○ No	
Complete Blood Count ○ Yes / ○ No		EKG ○ Yes / ○ No	
Blood Sugar Test ○ Yes / ○ No		Chest X-Ray ○ Yes / ○ No	
Colonoscopy ○ Yes / ○ No		Mammography ○ Yes / ○ No	

List any past surgeries, hospitalizations, injuries (broken bones, joint sprains, burns, falls, car accidents etc.) or dental work (root canal, mercury or ceramic fillings, implants, caps, dentures etc.):

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____
6. _____ Date _____
7. _____ Date _____
8. _____ Date _____
9. _____ Date _____
10. _____ Date _____

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Women's Health

Check all of the symptoms that apply to you:

○ hot flashes ○ vaginal dryness ○ breast tenderness ○ mood swings
○ bloating ○ night sweats ○ irritability/impatience ○ headaches
○ cramping ○ clots

Men's Health

Check all of the symptoms that apply to you:

○ urinary pain ○ urinary urgency ○ urinary hesitancy ○ low libido
○ hernia ○ prostate problems ○ discharges/sores ○ sexual difficulties
○ testicular mass/pain

Date of last prostate exam (if applicable): _____

Family History

Indicate whether any family members have had any of the following:

	Relation To You		Relation To You
Alcoholism ○ Yes / ○ No		Diabetes ○ Yes / ○ No	
Allergies ○ Yes / ○ No		Drug Abuse ○ Yes / ○ No	
Alzheimer's Disease ○ Yes / ○ No		Heart Disease ○ Yes / ○ No	
Arthritis ○ Yes / ○ No		High Blood Pressure ○ Yes / ○ No	
Asthma ○ Yes / ○ No		Kidney Disease ○ Yes / ○ No	
Cancer (indicate type) ○ Yes / ○ No		Osteoporosis ○ Yes / ○ No	
Depression ○ Yes / ○ No		Stroke ○ Yes / ○ No	
Other Illnesses ○ Yes / ○ No		Thyroid Condition ○ Yes / ○ No	

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Symptom Review

Check all symptoms occurring presently or within the past 6 months:

General

- ○ recent weight change
- ○ cold intolerance
- ○ heat intolerance
- ○ daytime sleepiness
- ○ early waking
- ○ insomnia
- ○ fatigue
- ○ fever
- ○ other _____

Head / Eyes / Ears

- ○ headache / migraines
- ○ ear pain
- ○ ear buzzing / ringing
- ○ changes in hearing
- ○ itchy / watery eyes
- ○ changes in vision
- ○ eye pain
- ○ other _____

Musculoskeletal

- ○ low back pain
- ○ foot cramps / pain
- ○ joint deformity
- ○ joint pain / stiffness
- ○ muscle pain
- ○ muscle weakness
- ○ muscle spasms/cramps
- ○ tendonitis
- ○ TMJ problems
- ○ tension headaches
- ○ other _____

Skin / Nails

- ○ acne (face / torso)
- ○ athlete's foot/jock itch
- ○ dandruff
- ○ bumps on arms
- ○ cellulite
- ○ dark circles under eyes
- ○ lack of sweating
- ○ sweating easily
- ○ eczema / hives / rash
- ○ psoriasis
- ○ oily skin
- ○ itchy skin
- ○ dry skin
- ○ suspicious moles
- ○ changes in pigment
- ○ skin darkening
- ○ hair loss
- ○ ridging / spots on nails
- ○ soft nails
- ○ thickening of nails
- ○ other _____

Urinary

- ○ UTI
- ○ incontinence / dribbling
- ○ discomfort on urination
- ○ frequent urination
- ○ blood in urine
- ○ other _____

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Gastrointestinal

- ○ bloating
- ○ constipation
- ○ diarrhea
- ○ blood or mucus in stool
- ○ pain with stool
- ○ cramps / indigestion
- ○ flatulence
- ○ belching
- ○ acid reflux
- ○ haemorrhoids
- ○ anal fissures
- ○ undigested food in stool
- ○ food intolerances
- ○ jaundice
- ○ nausea
- ○ other _____

Respiratory

- ○ breathlessness
- ○ exercise intolerance
- ○ dry cough
- ○ productive cough
- ○ hoarseness
- ○ seasonal allergies
- ○ nasal congestion
- ○ snoring
- ○ wheezing / asthma
- ○ sore throat
- ○ other _____

Cardiovascular

- ○ chest pain / angina
- ○ heart palpitations
- ○ irregular pulse
- ○ easy bruising
- ○ varicose veins
- ○ swollen ankles / feet
- ○ high blood pressure
- ○ cold hands and feet
- ○ other _____

Lymph / Immune System

- ○ enlarged lymph nodes
- ○ painful / tender nodes
- ○ swelling of extremities
- ○ frequent infections
- ○ slow wound healing
- ○ other _____

Mind / Nervous System

- ○ anxiety
- ○ depression
- ○ irritability / impatience
- ○ difficulty concentrating
- ○ poor memory
- ○ fearful / chronic worry
- ○ panic attacks
- ○ numbness / tingling
- ○ speech difficulty
- ○ seizures
- ○ tremor / trembling
- ○ dizziness / vertigo
- ○ lightheaded / fainting
- ○ loss of balance
- ○ other _____

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Eating / Appetite

○ can't gain weight	○ can't lose weight	○ frequent dieting
○ poor appetite	○ always hungry	○ emotional eater
○ salt cravings	○ carbohydrate cravings	○ sugar cravings
○ caffeine-dependent	○ binge eating	○ bulimia / anorexia

○ other _____

What would you like to gain from today's visit?

_____

_____

_____

Indicate on the figure below any areas of concern: