PATIENT INTAKE FORM

____

FIRST NAME **LAST** **DATE OF BIRTH**

Address____

Postal Code_______________

Phone Home _______________________**Cell**____________________________

Emergency Contact ____

E-Mail Address ___________________________**Occupation**_________________

Family Physician: ____
NAME PHONE

Family Physician's Diagnosis: ____

Reason for Today's Visit:____

How did you hear about us?____

Your Treatment Goals: ○ Relief of Present Symptoms ○ General Well Being
○ Long Term Health Care
Have you had massage before? __________/_________
YES NO
Have you had Acupuncture Before? _________/__________
YES NO
Have You Taken Chinese Herbal Medicines? _________/_________
YES NO
Please check the forms of Therapy or Treatments that you currently use:
O Physio O Massage O Yoga O Naturopath O Chiropractor O Other

Please specify:

MEDICAL HISTORY

Have you seen a physician in the past 5 years?
Are you in a high-risk category for infectious disease?

Are you currently taking medication including Herbs and Supplements?
If so please list them.
____

Are there any areas of your body that cause you pain or concern? Please describe:____

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Do you currently have or have you ever had any of the following?

AIDS	Fibromyalgia	Osteoporosis
Alcoholism	Gall Stones	Pacemaker
Allergies	HIV	Respiratory Condition
Anemia	Heart Condition	Rheumatic Fever
Arthritis	Hemophilia	Sinus Problems
Asthma	Hepatitis	Skin Conditions
Cancer	High/Low Blood Pressure	Spinal Injury
Deep Vein Thrombosis	Jaw Pain	Sprains or Fractures
Diabetes	Kidney Disease/Stones	Stroke
Digestive Disorders	Liver Conditions	Thyroid Problem
Drug Addiction	Mental Illness	Tuberculosis
Emotional Disorder	Migraine Headaches	Ulcers
Epilepsy	Multiple Sclerosis	Ulcerative Colitis

Other (Please Specify): ____

Do you currently or have you ever experienced any of the following?

Shortness of Breath   Night Sweats

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Lifestyle:

Describe your diet? ____

Do you crave any particular foods? ____

Exercise? Yes No How often? ___________ Type? ____________________

Stress Level: Low – 1 2 3 4 5 6 7 8 9 10 - High

Sleep: Hours per night ________ Rested in AM? ________

Trouble falling asleep? ______ Trouble staying asleep? ______

Do you get up to urinate more than once? _________________

Work: Enjoy work? Yes No Hours per week working ___________

Hobbies: ____

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee -				Water -			
Tobacco -				Recreational Drugs -			
Alcohol -				Soda pop -			

Have you ever been a smoker?

Symptom Survey (please check all that apply)

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4 low appetite
0 1 2 3 4 loose stools
0 1 2 3 4 gas/abdominal bloating
0 1 2 3 4 fatigue after eating
0 1 2 3 4 hemorrhoids
0 1 2 3 4 bruise easily
0 1 2 3 4 anemia
0 1 2 3 4 ravenous appetite
0 1 2 3 4 heartburn/acid reflux
0 1 2 3 4 mouth sores
0 1 2 3 4 belching or vomiting
0 1 2 3 4 gums bleeding/swollen
0 1 2 3 4 thirst Hot? Cold?
0 1 2 3 4 bad breath

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0 1 2 3 4 abnormal sweating
0 1 2 3 4 allergies
0 1 2 3 4 asthma
0 1 2 3 4 shortness of breath
0 1 2 3 4 cough
0 1 2 3 4 dry nose/mouth/skin/throat
0 1 2 3 4 fatigue
0 1 2 3 4 catch colds easily
0 1 2 3 4 tired after little exertion
0 1 2 3 4 general weakness
0 1 2 3 4 nasal discharge
0 1 2 3 4 sinus congestion

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0 1 2 3 4 sore, cold or weak knees
0 1 2 3 4 low back pain
0 1 2 3 4 frequent urination
0 1 2 3 4 urinary incontinence
0 1 2 3 4 ear/hearing problems
0 1 2 3 4 feel cold often
0 1 2 3 4 swollen ankles
0 1 2 3 4 poor memory
0 1 2 3 4 hair loss
0 1 2 3 4 infertility

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0 1 2 3 4 early morning diarrhea — low normal high libido

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0 1 2 3 4 irritable	0 1 2 3 4 muscle spasms/twitches
0 1 2 3 4 ligament/tendon issues	0 1 2 3 4 numb extremities
0 1 2 3 4 tight feeling in chest	0 1 2 3 4 dry, irritated eyes
0 1 2 3 4 alternating diarrhea/constipation	0 1 2 3 4 ear ringing
0 1 2 3 4 sigh frequently	0 1 2 3 4 anger easily
0 1 2 3 4 neck/shoulder tension	0 1 2 3 4 red eyes

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0 1 2 3 4 feel heart beating	0 1 2 3 4 chest pain
0 1 2 3 4 insomnia	0 1 2 3 4 disturbing dreams
0 1 2 3 4 sores on tip of tongue	0 1 2 3 4 restlessness
0 1 2 3 4 anxiety	0 1 2 3 4 palpitations

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0 1 2 3 4 dizzy upon standing	0 1 2 3 4 feeling of heaviness
0 1 2 3 4 see floaters in eyes	0 1 2 3 4 nausea
0 1 2 3 4 heat in palms or soles	0 1 2 3 4 foggy thinking
0 1 2 3 4 afternoon fever	0 1 2 3 4 enlarged lymph nodes
0 1 2 3 4 night sweats	0 1 2 3 4 cloudy urine
0 1 2 3 4 frequently flushed face	

Urination: (Circle all that apply) Burning Urgent Scanty

Difficult Profuse Dribbling More than 1x a night

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Bowel Movements: Frequency _____________

Consistency (circle): well-formed hard loose alternates between formed and loose

Do you ever notice any undigested food, blood or mucous? ___________________________________

Are you thirsty? Yes No If so, do you crave warm or cold drinks? ____________________

Upon waking, do you have a bitter taste in your mouth? __________________________

Do you find that you “run” particularly hot or cold? ____

How is your energy in general? ____

Do you often get headaches or migraines? Yes No

How do you feel emotionally right now? ____

____

Women Only:

Are you currently pregnant? ________ Are you on the birth control pill? ________

# of pregnancies_____ # of live births_____ # of miscarriages_____ # of abortions_____

How old were you when you had your first period? _____

Have you experienced menopause? Yes No When? ______________

If you are experiencing menopausal symptoms, please describe: __________________________

____

Vaginal Discharge? Yes No Clear/White/Yellow/Green Itch/Burn/Pain/Foul Odor

Is your period regular?______ When was the first day of your last period?________________

# of days from the start of one period to the start of the next ________

Average number of days of flow: ______ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Purple

Blood clots? Yes No

Do you get pain or cramps? Yes No Severe? Yes No Low Back/Low Abdomen

Nature of pain (circle): Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?

Water retention Breast tenderness/swelling Depression Irritability Migraines

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

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Men Only:

Date of last prostate check up: ___________ Results: _________________________________

Circle all that apply: Groin pain Decreased libido Testicular pain Impotence

Painful urination Difficult urination Dribbling urination Incontinence

Premature ejaculation Nocturnal emissions Increased libido

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Please read the following information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese medicine and the other treatments provided at this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. You should be aware that the following side effects can occur.

- **Drowsiness can occur in some small number of patients, if so, we recommend that you do not drive;**
- **Minor bleeding or bruising can occur from acupuncture;**
- **In less then 3% of patients, symptoms may worsen for 1-2 days before improving. Please advise your practitioner if symptoms worsen for more then 2 days.**
- **Fainting can occur in certain patients, particularly at the first treatment.**

I, the undersigned, consent to receive treatment offered at Qi Integrated Health; I also acknowledge full responsibility for payment of services.

I, the undersigned, certify that all of the above medical history provided is true to the best of my knowledge, and I have not knowingly omitted information.

Cancellation Policy: Cancellations are accepted up to 48 hours before scheduled date of appointment. Missed appointments are charged one half of the cost of the appointment.

Name (Please Print) Signature

Name Parent Consent (Under 18 Yrs) Signature

DATE SIGNED: _______/________/________/
DAY MONTH YEAR

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