Kanata Acupuncture
Patient Intake Form

This is a **confidential** questionnaire to help us determine the best treatment plan for you.
If you have any questions, please ask your therapist. Thank you.

Name Date:
Home Address
City Province Postal Code
Home Ph# Bus Ph# Cell Ph#
E-mail Occupation
Emergency Contact Person Ph#
Who should we thank for referring you to this office?

Sex M/F Height Weight Birth Date
Marital Status Number of Children
Have you received acupuncture therapy before?
With Whom? When

Please indicate any significant illness you or a blood relative (parent, sibling etc) have had:

	You	Relative
Cancer		
Hepatitis		
High Blood Pressure		
Rheumatic Fever		
Infectious Diseases		

	You	Relative
Diabetes		
Heart Disease		
Seizures		
Emotional Disorders		
Tuberculosis		

Have you been diagnosed with any of the following?

☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ Herpes ☐ HPV ☐ AIDS

List any medications or supplements you are currently taking (continue on back if required)

Type	Dosage	Reason	How long

What are the main health problems for which you are seeking treatment? ____________________

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What other forms of treatment have you sought? ____________________

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____

List any other health problems you now have: ____________________

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List any allergies, food sensitivities or food cravings that you have: ____________________

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____

List any accidents, injuries or hospitalizations (include date): ____________________

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Describe your typical diet (breakfast,lunch,dinner,snacks, desserts) ____________________

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____

Please indicate the use and frequency of the following: (indicate with and X in the appropriate box)

	Yes	No	Frequency
Coffee			
Alcohol			
Tobacco			
Soda Pop			
Recreational Drugs			
Water intake			

How do you FEEL about the following areas in your life: (indicate with and X in the appropriate box)

	Great	Good	Fair	Poor	Bad	Comments
Significant other						
Family						
Diet						
Sex						
Work						
Exercise						
Spirituality						

WOMEN ONLY

Age of 1st period ____ Are you pregnant? ____ #Pregnancies ____ #Live Births ____
Age of last period ____ # Miscarriages ____ #Therapeutic Abortions ____
days between periods ____ date of last OBGYN exam ____
days flow ____ Mammogram (result) ____
Clots? Y/N Color of flow ____

Have you been diagnosed with: O Fibroids O Ovarian Cysts O Fibrocystic Breasts O Endometriosis O PID O Other:______________

Location of Menstrual Pain:______________________

Types of Pain (please indicate before/during/after menses)

Cramping:__________	Burning:___________	Dull:______________
Consistent:_________	Stabbing:___________	Stabbing:___________
Aching:____________	Bloating:___________	Intervals:___________

Other Symptoms related to menses: ____

O Discharge	O Vaginal Dryness	O Nausea	O Constipation
O Swollen Breasts	O Mood Swings	O Poor appetite	O Hot flashes
O Increased libido	O Headache	O Ravenous appetite	O Night Sweats
O Decreased libido	O Insomnia		

MEN ONLY

Date of last prostate Checkup ____ PSA Results ____
Frequency of urination: Daytime ____ Night time ____
Color of urine ______________ O Clear O Murky Odor:____________________

Symptoms Related to prostate:

O Prostate problems	O Delayed stream	O Dribbling	O Incontinence
O Rectal dysfunction	O Increased libido	O Decreased libido	O Premature ejaculation
O Back pain	O Groin pain	O Testicular pain	O Retention of urine
O Impotence	O Other		

GENERAL SYMPTOMS

O Lack of appetite	O Abdominal pain	O Easily stressed	O Fatigue
O Excessive appetite	O Chest pain	O Insomnia	O Dizziness
O Loose stool	O Sciatic pain	O Heart palpitations	O Tendency to faint
O Diarrhea	O Headaches	O Nightmares	O Cold hands/feet
O Colitis	O Pain in genitals	O Mentally restless	O Easily bruised
O Constipation	O Angina pains	O Claustrophobia	O Prolonged bleeding
O Hemorrhoids	O Lower back pain	O Indecisive	O Eye problem
O Blood in stool	O Cough	O Low sex drive	O Jaundice
O Black tar stool	O Skin problems	O Gall stones	O Brittle/soft nails
O Pale stool	O Nasal problems	O Kidney stones	O Hearing impairment
O Digestive problems	O Short of breath	O Urinary problems	O Ear ringing
O Vomiting	O Bronchitis	O Muscle spasms	O Hair loss
O Belching	O Asthma	O Twitching	O Recent medications
O Heartburn	O Frequent colds/flu	O Knee problems	O Edema
O Bloating	O Allergies	O Sudden weight loss	O Other (please specify)
O High cholesterol	O Hay fever	O Sudden weight gain	________________________