

Acupuncture Intake Form:

Name: _____
 Date: _____
 Address: _____
 Phone: _____

Email: _____
 Emergency Contact: _____
 Primary Physician: _____
 Occupation: _____

Would you like to be emailed about clinic information and updates: Yes / No

Health concerns in order of importance:

- 1.
- 2.
- 3.
- 4.

Past medical history:

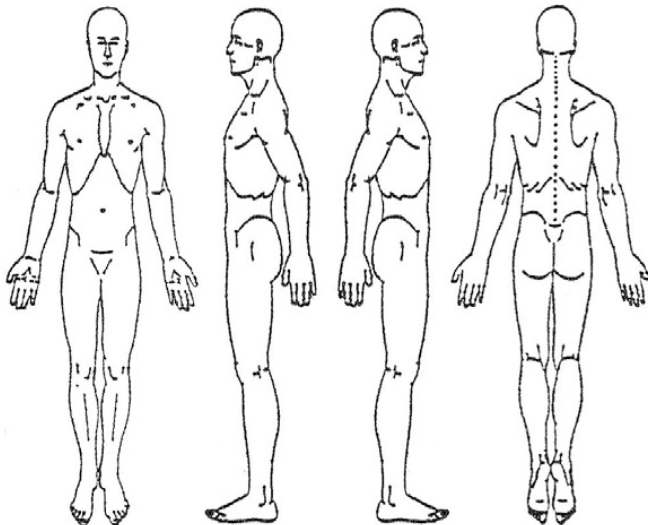
Family medical history:

Please list any supplements or drugs that you are currently on:

Please list any allergies you may have:

Pain:

Please circle the area of discomfort:



Is the pain (circle all that apply):

Sharp aching dull burning
 moving cramping fixed other

Does the pain get better with:

Pressure heat cold exercise other

Does the pain get worse with:

Pressure heat cold exercise other



Retail Store & Pharmacy:
1111 West Broadway
Vancouver, B.C., V6H 1G1
(604) 733 - 5323

Health Centre:
G104 - 2480 Spruce
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(604) 734 - 7760

For each symptom below, please rate its severity on a scale of 1-3. Leave blank if it doesn't apply.

Pi:

- Heaviness in the head/body
- Fatigue after eating
- Difficulty getting up in the am
- Water retention
- Muscular fatigue
- Bruise easily
- Sweat easily
- Increased thirst
- Pensive overthinking
- Easily gains weight/hard to loose
- Heartburn
- Loose stool
- Constipation
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Fei:

- Dry cough
- Cough with phlegm
- Sinus infection/congestion
- Weak immune system
- Skin rashes/hives
- Shortness of breath
- Allergies/asthma
- Alternate fevers/chills
- Grief/sadness
- Nasal discharge/drip
- Snoring

Xin:

- Palpitations
- Tongue/mouth ulcers/cankers
- Bitter taste in mouth
- Chest pain/tightness
- Insomnia/sleep waking
- Restless / easily agitated
- Vivid dreams
- Aversion to heat

Gan:

- Irritability/frustration/impatience
- Depression
- Stress
- Emotional eating
- Unfulfilled desires
- Pain under the rib cage
- Neck/shoulder tension
- Brittle nails
- Sighing
- Genital itching/pain/rashes
- PMS
- Feeling of lump in the throat
- Headaches/migraines
- Dizziness
- Blurred vision/poor night vision
- Visual problems/floaters

Shen:

- Frequent urination
- Bladder infection
- Tinnitus
- Ankle swelling
- Fear
- Crave salty food
- Hearing problems
- Night sweats/hot flashes
- Cold hands/feet



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Women's health:

Date of your last period: _____

How many days is your regular cycle? _____

Do you have a heavy, light or average flow? _____

Does your blood contain clots? Yes / No

Circle the color of your blood: brightred dark brown pink red dark red

Consistency of blood: watery thick average

Do you have menstrual pain? If yes, please describe when you experience the pain, as well as the location and sensation:

Other PMS signs (circle all that are applicable):

Breast tenderness
cramps
acne
fatigue

change in bowels
bloating
headaches
nausea

moodiness
fatigue
night sweats
sleep disturbances

Any other concerns?:



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Informed Consent

Statement of Acknowledgement

As a patient of this Health Centre I have read the information and understand that the form of medical care is based on alternative and other supportative principles and practices. As Finlandia is an integrated health centre, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Signature

Date