ACUPUNCTURE
MONT TREMBLANT

Confidential Patient Intake

FileNo_____

Name Sex Date
Birth Date Âge Occupation
Address
Postal Code
Tel No : Cell Work
Email (confidential):
Emergency Contact: Name Tel. No
Physician's name :
Last consultation date Reason:
Test results, etc
Referred to me by

Reason(s) for Consultation in ACUPUNCTURE
First time with Acupuncture? Yes No

Objectives & expectations with acupuncture
When did this condition start?
Do you have a medical diagnosis?
Any treatment(s), therapy (ies)?

Worse with
Better with

Illnesses you have, or have had:

past (p) currently (c)	(p)	(c)		(p)	(c)
alcoholism			heart disease		
anemia			hepatitis		
arthritis			HIV/AIDS		
asthma			hypertension		
cancer			miscarriage		
chronic fatigue			thyroid disease		
diabetes			stroke		
digestive disorders			other		
epilepsy			osteoporsis		

Medical History Surgeries, accidents (when)

For office use

TB Y N Pacemaker Y N Bloodthinners Y N

Cortisone injections Y N Prosthesis Y N

General Lifestyle (please circle)

sleep well?	yes	no	3 meals/day?	yes	no
6-8 hours?	yes	no	diet often?	yes	no
easy to fall asleep?	yes	no	eat out often?	yes	no
sleep all night?	yes	no	coffee?	yes	no
alcoholic beverages?	yes	no			
tobacco?	yes	no	green/herbal tea?	yes	no
recreational drugs?	yes	no	refined sugar?	yes	no
enjoy your work?	yes	no	artificial sweeteners?	yes	no
take vacations?	yes	no			
exercise?	yes	no	carbonated drinks?	yes	no

if so, what/how often? _____

main interests/hobbies?

if so, what? _____

Are you a vegetarian? yes no **Do you eat spicy food often?** yes no

Prescription medications, over-the-counter medications, vitamins or supplements, birth control pills, etc. used in last three months:

1.
2.
3.
4.
5.
6.
7.
8.

Please circle if you have experienced any of these conditions in the last three months.

poor appetite	appetite change	poor sleep	fatigue	fevers	strong thirst
chills	night sweats	sweat easily	tremors	cravings	
poor balance	bleed/bruise easily	weight loss	weight gain	sudden energy drop	

Sp

past	current		past	current		past	current	
☐	☐	nausea / vomiting	☐	☐	gas	☐	☐	diarrhea
☐	☐	belching	☐	☐	abdominal bloating	☐	☐	constipation
☐	☐	heartburn	☐	☐	abdominal pain	☐	☐	blood in stools / black
☐	☐	bad breath	☐	☐	decreased appetite	☐	☐	pus in stools
☐	☐	bleeding gums	☐	☐	indigestion	☐	☐	hemorrhoids
☐	☐	ulcers	☐	☐	low energy / fatigue	☐	☐	anal fissures
☐	☐	excessive appetite	☐	☐	crave sweets	☐	☐	rectal pain
☐	☐	change in appetite	☐	☐	decreased sense of taste /smell	☐	☐	nose bleeds
☐	☐	sweet taste in mouth	☐	☐	difficulty swallowing	☐	☐	recurring sore throat
☐	☐	often feel pensive/thoughtful						
☐	☐	edema				☐	☐	laryngitis / hoarse voice

Lu

past	current		past	current		past	current	
☐	☐	frequent colds	☐	☐	asthma	☐	☐	often feel sad
☐	☐	sinus infection	☐	☐	bronchitis	☐	☐	crave pungent foods
☐	☐	cough	☐	☐	pneumonia	☐	☐	dry skin
☐	☐	cough with blood	☐	☐	COPD	☐	☐	itching
☐	☐	production of phlegm	☐	☐	acne	☐	☐	hay fever or allergies
☐	☐	rashes, hives, eczema or psoriasis						

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past	current		past	current		past	current	
☐	☐	frequent urination	☐	☐	frequent urinary tract infections	☐	☐	impotence
☐	☐	urgency to urinate	☐	☐	frequent vaginal infections	☐	☐	premature ejaculation
☐	☐	pain on urination	☐	☐	pelvic inflammatory disease	☐	☐	testicular lumps
☐	☐	urine incontinence	☐	☐	abnormal PAP smear	☐	☐	prostatitis
☐	☐	weak urine stream	☐	☐	irregular periods	☐	☐	genital itching/ pain
☐	☐	blood in urine	☐	☐	premenstrual syndrome			
☐	☐	kidney stones	☐	☐	painful menstrual periods	☐	☐	decreased libido
☐	☐	low back pain	☐	☐	abnormal bleeding	☐	☐	ear ringing – low pitch
☐	☐	sore / weak knees	☐	☐	menopause symptoms	☐	☐	ear ringing – high pitch
☐	☐	crave salty foods	☐	☐	breast lumps	☐	☐	ear infections
☐	☐	often feel afraid	☐	☐	decreased hearing			

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past	current		past	current		past	current	
☐	☐	dry eyes	☐	☐	insomnia	☐	☐	migraine
☐	☐	red eyes	☐	☐	excessive /vivid dreams	☐	☐	dizziness
☐	☐	eye inflammation	☐	☐	grinding teeth	☐	☐	fainting
☐	☐	blurred vision	☐	☐	depression	☐	☐	seizures
☐	☐	poor night vision	☐	☐	anxiety / stress	☐	☐	localized weakness
☐	☐	floaters (spots in visual field)	☐	☐	irritability	☐	☐	numbness / tingling of limbs
☐	☐	visual changes	☐	☐	treated for emotional / psychological problems	☐	☐	tremors
☐	☐	glasses / contact lenses				☐	☐	poor concentration
☐	☐	cataracts	☐	☐	indecisiveness	☐	☐	paralysis
☐	☐	crave sour foods	☐	☐	often feel angry	☐	☐	aversion to wind
☐	☐	tendinitis	☐	☐	gallstones			

Ht

past	current		past	current		past	current	
☐	☐	high blood pressure	☐	☐	chest pain or pressure	☐	☐	blood clotting disorders
☐	☐	low blood pressure	☐	☐	jaw, neck, shoulder or arm pain	☐	☐	phlebitis
☐	☐	palpitations	☐	☐	nausea	☐	☐	poor memory
☐	☐	irregular heart beat	☐	☐	swollen hands or feet	☐	☐	crave bitter foods

past	current		past	current		past	current	
☐	☐	fevers	☐	☐	chills	☐	☐	headache
☐	☐	frequent or strong thirst	☐	☐	hands / feet	☐	☐	neck stiffness
☐	☐	tend to feel warmer than others	☐	☐	tend to feel colder than others	☐	☐	concussion
☐	☐	night sweats	☐	☐	cold sweats	☐	☐	enlarged lymph
☐	☐	sweat easily	☐	☐	prefer warm food and drink			
☐	☐	prefer cold food and drink						

past	current		past	current		past	current	
☐	☐	venereal disease	☐	☐	chicken pox	☐	☐	meningitis
☐	☐	herpes oral / genital						

Men's Health

hernias	p	c	impotence	p	c
testicular pain	p	c	premature ejaculation	p	c
testicular masses	p	c	sexually transmitted		
prostate disease	p	c	disease	p	c

Women's Health

age of first menses _____
date of onset of last menses _____
length of cycle (days)_____
duration of menses(days) _____

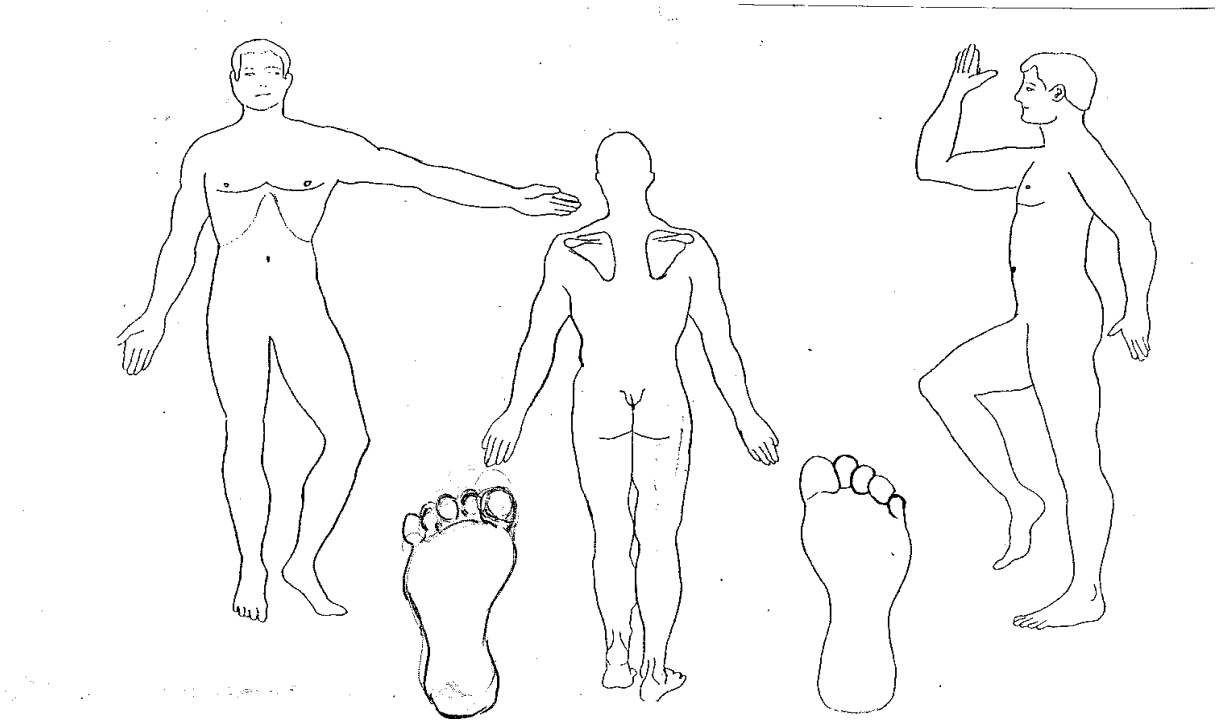
painful intercourse p c

regular cycles	yes	no	sexually transmitted disease	p	c
painful menses	p	c			
heavy flow	p	c	vaginal discharge	p	c
bleeding between periods	p	c	difficulty conceiving	p	c
			number of pregnancies	_____	
clots	p	c	number of live births	_____	
breast pain/tenderness	p	c	number of Caesarians	_____	
breast lumps	p	c	number of miscarriages	_____	
ovarian cysts	p	c	number of abortions	_____	
uterine fibroids	p	c			
menopausal symptoms	p	c			

practice birth control? yes no if yes, what type and how long? _____
if you're on birth control pills, what are you taking and how long? _____
Pregnant?_____
Trying to get pregnant?_____

Please indicate painful or distressed areas

SHADE chronic pain **XXX acute pain** **SOLID LINES scars**



Use this space to mention any additional information regarding your condition.

Cancellation Policy

Please give 24 hours notice for any cancellation or change to your appointment. Otherwise, a charge for the full amount of the missed treatment will be applied. Thank-you for your understanding.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature _____ **Date** _____