

**ARBUTUS ACUPUNCTURE AND MASSAGE CLINIC  
PATIENT INTAKE FORM**

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: F M

\_\_\_\_\_  
OCCUPATION: \_\_\_\_\_

\_\_\_\_\_  
REFERRED BY: \_\_\_\_\_

PHONE # (H) \_\_\_\_\_ (W) \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

IN EMERGENCY NOTIFY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

MAIN PROBLEM: \_\_\_\_\_

WHEN DID THE PROBLEM BEGIN: \_\_\_\_\_ MEDICAL DIAGNOSIS: \_\_\_\_\_

WHAT OTHER TREATMENTS HAVE YOU TRIED? \_\_\_\_\_

HAVE YOU TRIED TCM BEFORE \_\_\_\_\_ ACUPUNCTURE \_\_\_\_\_ TUI NA \_\_\_\_\_ HERB \_\_\_\_\_ OTHER \_\_\_\_\_

ALLERGIES? (DRUGS, CHEMICALS, FOODS ETC.) \_\_\_\_\_

OCCUPATIONAL STRESS (CHEMICAL, PHYSICAL, PSYCHOLOGICAL) \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

SUPPLEMENTS: \_\_\_\_\_

ARE YOU ON A RESTRICTED DIET OR EXERCISE PROGRAM? \_\_\_\_\_

PLEASE DESCRIBE YOUR AVERAGE DIET: \_\_\_\_\_

HOW MANY MEALS DO YOU EAT A DAY? \_\_\_\_\_ DO YOU HAVE ANY CRAVINGS? \_\_\_\_\_

PLEASE CIRCLE THE PRODUCTS THAT ARE USED (CIGARETTES, ALCOHOL, DRUGS, COFFEE, TEA, SOFT DRINKS)

HOW OFTEN ARE THESE PRODUCT(S) USED A WEEK? \_\_\_\_\_

**MEDICAL HISTORY**

CANCER \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ HEART DISEASE \_\_\_\_\_ DIABETES \_\_\_\_\_

THYROID DISEASE \_\_\_\_\_ VENEREAL DISEASE \_\_\_\_\_ HEPATITIS \_\_\_\_\_

BLEEDING DISORDERS \_\_\_\_\_ HIGH/LOW BLOOD PRESSURE \_\_\_\_\_

INDICATE AREAS OF PAIN OR DISTRESS:

## GENERAL

- Any history of bleeding disorders
  - Bleed or bruise easily
  - Heart palpitations
  - Shortness of breath
  - Shortness of breath on exertion
  - Recurrent infections
  - Night sweats
  - Sweating easily
  - Edema
  - Fatigue
  - Sudden energy drop (time of day\_\_\_\_\_)
  - Climate preference (warm/cold)
  - Strong thirst (hot/cold)
  - Thirst, no desire to drink
  - Pain:where/type\_\_\_\_\_
- 
- 

Notes:

## HEAD/EARS/EYES/NOSE/THROAT

- Headaches
- Migraines
- Dizziness
- Ringing in ears
- Earache/Ear discharge
- Blurry vision
- Spots in front of eyes
- Eye dryness/pain
- Nasal discharge
- Nose bleeds
- Grinding teeth
- Recurrent sore throat
- Swollen glands
- Sores on lips/mouth
- Other \_\_\_\_\_

Notes:

## DIGESTION

- Heartburn
- Bad breath
- Nausea
- Vomiting
- Anorexia
- Bulimia
- Abdominal pain/cramps
- Feeling of heaviness after eating
- Gas
- Bloating
- Belching
- Constipation
- Loose stools
- Undigested food in stools
- Mucus in stools
- Blood in stools
- Strong smelling stools
- Rectal pain
- Fissures
- Hemorrhoids
- Other \_\_\_\_\_

Notes:

## GENITO-URINARY

- History of bladder/kidney infections
  - Pain on urination
  - Urgency with urination
  - Frequent urination
  - Blood in urination
  - Decrease in urinary flow
  - Unable to hold urine
  - Incontinence at night
  - Kidney stones
  - Change in sexual drive
  - Prostate problems
  - Impotency
  - Other
- Do you wake up to urinate? Yes/No  
How many times? \_\_\_\_\_

Notes:

SLEEP

- Hours of sleep per night\_\_\_\_\_
- Quality of sleep\_\_\_\_\_
- Wake up at night
- Difficulty falling asleep
- Easily fall asleep
- Light sleeper
- Deep sleeper
- Wake up rested
- Nightmares
- Frequent dreams
- Other\_\_\_\_\_

Notes:

GYNECOLOGICAL

- # of Pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ # premature births \_\_\_\_\_ # of therapeutic abortions \_\_\_\_\_
- Age of 1<sup>st</sup> menses\_\_\_\_\_
- # of days between menses \_\_\_\_\_
- Duration of menses \_\_\_\_\_
- Irregular periods
- Light periods
- Heavy period
- Clots
- Painful periods
- Unusual vaginal discharge
- Vaginal pain
- PMS
- Fibroids
- Breast lumps
- Endometriosis
- Infertility
- Age of menopause\_\_\_\_\_
- Date of last PAP\_\_\_\_\_
- Other\_\_\_\_\_

- Do you practice birth control?      Yes   No
- Are you pregnant?                      Yes   No
- Are you trying to become pregnant?   Yes   No

Notes:

NEUROLOGICAL/BEHAVIOURAL

- Stroke
- Paralysis
- Poor balance
- Poor memory
- Difficulty concentrating
- Irritability
- Aggressive/bad temper
- Anxiety
- Depression
- Panic attacks
- Other\_\_\_\_\_

Notes:

TONGUE:

PULSE:

Signature \_\_\_\_\_ Date\_\_\_\_\_

In consideration to your fellow patient and therapists, 24 hours notice of cancellation must be given or a fee will be charged.