New Patient Intake Form for Acupuncture & Shiatsu

This information is essential to the diagnostic procedure to help us provide you with the best possible treatment. Please fill out the following questions as accurately as you can.

All information is kept in your personal file and will not be released by anyone to any body without your written permission.

Name:____
Phone: H(   ) ______ -- ___________ W(   ) ______ -- ___________
Address:____
City: ____________________ Province_______________ Postal Code: ___________
Email Address: (optional)____
Occupation:
____
Today's Date: _____________ Birth Date: __________ Height: _____ Weight: _____

Doctors Name(s): ______________________Phone: (   ) ______ -- ____________
Referred By:____
Emergency Contact: ____
Phone: H(   ) ______ -- ___________ W(   ) ______ -- ___________
Relationship to Patient: ____

What is your principal complaint?
____
____
__

Previous diagnosis (by Medical Doctor etc.)?
____

Major Symptoms: Please list in order of importance what symptoms are of concern to you. *(most concerning to least)*

1____
__2____
____
3____
__

Cautions for Treatment (i.e. do you have epilepsy, hemophilia, on blood thinners, have a pacemaker, faint easily, are hypoglycemic, pregnant or possibly, been diagnosed with cancer or had recent surgeries or injuries etc.)______________________________

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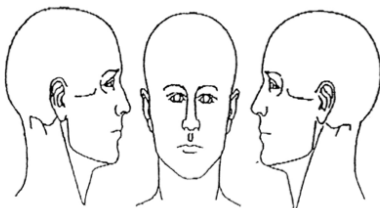
Details regarding Major Complaint: Where is the problem located?__________________
____(see diagram)
When did it start? How? ____
Have you had this condition before? When?_______________________________
Is it getting worse? __________ coming and going?_________ getting better?_________
How often does it bother you? ____
Is there a pattern- Time of day _____________ Time of year/season_________________
What makes it better? Heat______ Cold______ Pressure_____ Other________________
What makes it worse? Heat______ Cold ______ Pressure _____ Other ______________
Describe the pain, if any: Dull/Aches _______ Shooting_______ Other (pin prick, tight, squeezing, band sensation, expanding...) _______________________________________
Does the pain radiate anywhere?____
Severity of pain out of 10 (10= worst pain)______________________________________

Pain Diagram

Please note location of any surgery or injury scars, even minor ones:

QuickTime™ and a decompressor are needed to see this picture.



Please shade and code areas to indicate location of pain or discomfort.
P – Pins & Needles N – Numbness S – Spasm T – Tenderness
A – Aches R – Radiations B – Burning X – Stabbing

Birth: Was there anything significant about your birth?
____

Childhood illnesses, surgeries or accidents:

Age:___, ____
Age:___, ____
Age:___, ____
Age:___, ____

Adolescent illnesses, surgeries or accidents:

Age: ___, ____
Age: ___, ____
Age: ___, ____
Age: ___, ____

Adult illnesses, surgeries or accidents:

Age:___, ____
Age:___, ____
Age:___, ____
Age:___, ____

Family History: Please note all major illnesses in your immediate family like diabetes, heart disease, high blood pressure, neurological disorders, blood disorders, psychological disorders etc. ______________________________
____
____
____
____
____
____
____

Are you taking any medications? Please not all medications, herbs, vitamins, and minerals you take even if you take them only occasionally.: ________________
____
____
____

____

____

On a scale of 1 to 10 how much does your condition or symptoms affect your life?

1 2 3 4 5 6 7 8 9 10

What are your goals and expectations for therapy? ________________________________

____