

# I AM DESIGNED TO HEAL INTAKE FORM

Please complete this questionnaire carefully.

The information you provide will assist me in creating a complete health profile for you. All of your answers are confidential.  
If you have any questions, please ask.

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## PATIENT INFORMATION (Please Print)

**Dr**      **Mr**      **Mrs**      **Ms**      **Miss**

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Preferred Method of Contact:    **Home**      **Mobile**      **E-mail**

Who referred you to our practice?

**Website**    **Internet**    **Drove past**    **Local advertising**    **Other**

Have you ever had acupuncture before?    **Yes**      **No**

If yes, did you receive a diagnosis? \_\_\_\_\_

What is your primary reason(s) for treatment today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently receiving any other treatments for this condition?    **Yes**      **No**

If yes, please describe treatments and how effective they have been: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

For Females: Are you currently pregnant?    **Yes**      **No**

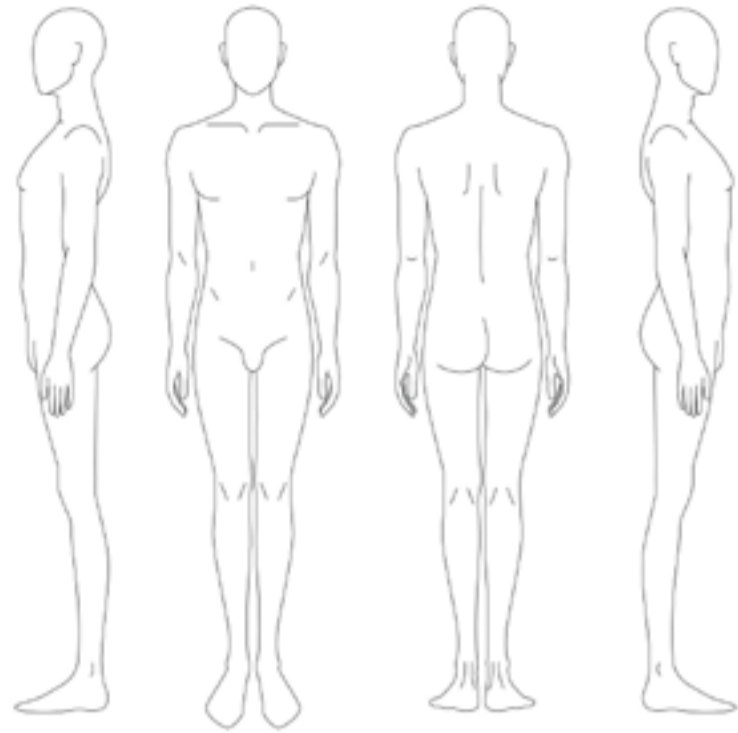
Do you have a contagious disease at this time?    **Yes**      **No**

If you are seeking treatment for a painful condition, please describe the pain and highlight the areas of pain below.

**PAIN CONDITION #1**

**Nature of the Pain**

- Constant
- Comes & Goes
- Fixed
- Moves
- One Side
- Both Sides
- Sharp
- Dull
- Burning
- Aching
- Spastic
- Numb



**Does the pain get better or worse with:**

- Heat - Better - Worse
- Cold - Better - Worse
- Motion - Better - Worse
- Rest - Better - Worse
- Pressure - Better - Worse
- Morning - Better - Worse
- Evening - Better - Worse

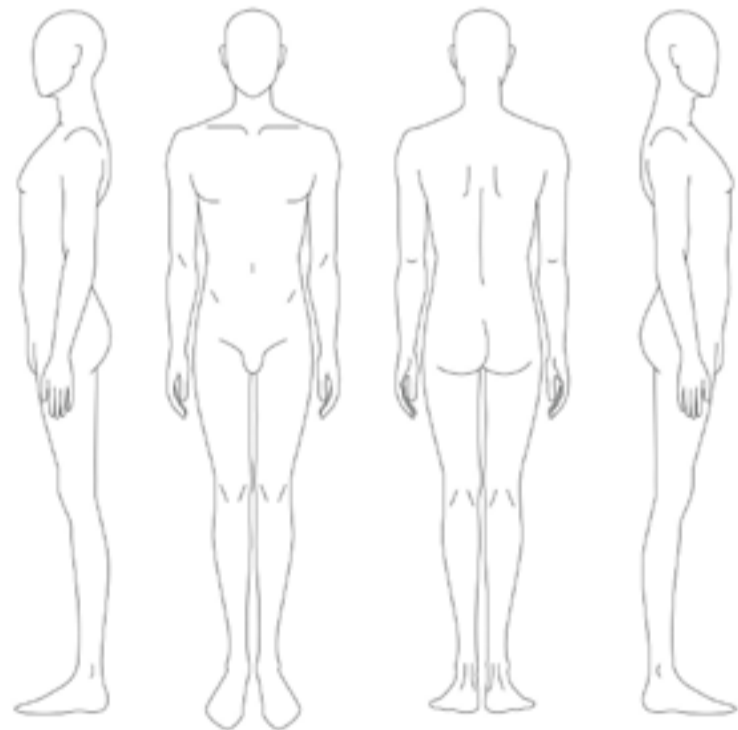
**Degree of Pain (please circle 1=Low; 10=High)**

1 2 3 4 5 6 7 8 9 10

**PAIN CONDITION #2**

**Nature of the Pain**

- Constant
- Comes & Goes
- Fixed
- Moves
- One Side
- Both Sides
- Sharp
- Dull
- Burning
- Aching
- Spastic
- Numb



**Does the pain get better or worse with:**

- Heat - Better - Worse
- Cold - Better - Worse
- Motion - Better - Worse
- Rest - Better - Worse
- Pressure - Better - Worse
- Morning - Better - Worse
- Evening - Better - Worse

**Degree of Pain (please circle 1=Low; 10=High)**

1 2 3 4 5 6 7 8 9 10



## GENERAL INFORMATION

Anorexia / Bulimia  
Chicken Pox  
Chronic Pain  
Fibromyalgia  
Rheumatoid Disease  
Rheumatic Fever  
Mumps

Hepatitis \_\_\_\_\_  
HIV  
Herpes / Cold Sores  
Lyme Disease  
Tuberculosis  
Thyroid Disease  
- Over active - Under active

Meningitis  
Scarlet Fever  
Mononucleosis  
Multiple Sclerosis  
Measles  
Pneumonia  
Tonsillitis

Cancer:

Other:

## HEAD / EYES / EARS / NOSE / THROAT

Bitter Taste  
Blurred Vision  
Cataracts  
Concussions  
Dry Mouth / Nose  
Ear Aches  
Excess Phlegm  
Eye Pain / Strain  
Facial Pain  
Glasses / Contacts  
Glaucoma

Grinding Teeth  
Goiter  
Gum Problems  
Headaches  
Hearing Aides  
Itchy Eyes  
Migraines  
Nose Bleeds  
Poor Hearing  
Red / Dry Eyes

Ringing in Ears  
Sinus Issues  
Spots in Eyes  
Swollen Glands  
Teeth Issues  
TMJ  
Trigeminal Neuralgia  
Watery Eyes

Other:

## RESPIRATORY

Asthma / Wheezing  
Frequent Colds  
Bronchitis  
Cough  
Cough & Bloods

Cough & Phlegm  
Emphysema  
Heavy Chest  
Pneumonia

COPD  
Difficult Breathing  
Tight Chest  
Short of Breath

Other:

## CARDIOVASCULAR

Anaemia  
Arteriosclerosis  
Easily Bruised  
Poor Circulation  
Blood Clots

Fainting  
High Cholesterol  
Low Blood Pressure  
Palpitations  
Chest Pain

Stroke  
High Blood Pressure  
Irregular Heart Beat  
Phlebitis  
Pace Maker

Heart Disease:

Other:



## GASTROINTESTINAL

Normal Stool  
Loose Stool  
Constipation  
Diarrhoea  
Undigested Food in Stool  
Mucous in Stool  
Blood in Stool  
Hernia

Strong Odour  
Pain Before Bowel Movement  
Pain After Bowel Movement  
Heartburn / Acid Reflux  
Abdominal Pain  
Appendicitis  
Bloating  
Liver Disorder

Celiac Disease  
Gas  
Hiccups  
Nausea / Vomiting  
Bad Breath  
Rectal Pain / Itching  
Haemorrhoids  
Ulcer

Number of Bowel Movements per Day

Other:

## GENITO-URINARY

Bed Wetting  
Bladder Infections  
Bloody Urine  
Frequent Urination  
Painful Urination  
Incontinence  
Premature Ejaculation

Urgent Urination  
Wake to Urinate  
Pale Urine  
Dark Urine  
Cloudy Urine  
Kidney Stones  
Nocturnal Emissions

Kidney Disease  
Libido Issues  
  
Yeast Infection  
Impotence  
Prostate Disorder

Other:

## GYNECOLOGICAL

Menopause  
Oral Birth Control Pills  
Intra-Uterine Device (IUD)  
Breast Lumps  
Genital Burning  
Genital Itching

Genital Discharge  
Genital Swelling  
Hysterectomy  
Endometriosis  
Fibroids  
Cysts

PMS - Headaches  
PMS - Backaches

## MENSTRUATION INFORMATION

Heavy Periods  
Light Periods  
Irregular Periods  
Pain Before  
Pain During  
Pain After

## DESCRIBE THE MENSTRUAL BLOOD

Dark Red  
Light Red  
Bright Red  
Pale Red  
Brown  
Thin / Watery  
Very Thick  
Clots

Number of Days Between Periods  
  
Number of Days of Period

Other:

## SKIN & HAIR

Acne  
Burning Skin  
Dandruff  
Dermatitis  
Discolorations

Eczema  
Fungal Infection  
Hair Loss  
Hot Flashes  
Heavy Sweating

Not Able to Sweat  
Hives  
Itchy / Dry Skin  
Psoriasis  
Rashes

Shingles  
Warts

Other:



## NEURO-PSYCHOLOGICAL

ADD / ADHD

Addiction

Anxiety

Depression

Easily Stressed

Epilepsy

Irritability

Mental Illness

Numbness

'Foggy' Feeling

Poor Coordination

Parkinson's Disease

Poor Memory

Seizure

Vertigo / Dizziness

Other:

## MUSCULOSKELETAL

Osteoarthritis

Rheumatoid Arthritis

Atrophy

Body Heaviness

Joint Pain

Scoliosis

Limited Motion

Limited Use

Back Pain

Muscle Pain

Muscle Cramps

Weight Gain

Neck Pain

Rib Pain

Weight Loss

Broken Bones:

Other:

## DO YOU HAVE ANY OF THE FOLLOWING

Pacemaker

Surgical Replacements

Implants

Haemophilia

Sensitive Skin

Fear of Needles

Latex Allergy

Nut Allergy

Other Allergy:

Other:

## FAMILY HISTORY

Alcoholism

Allergies

Asthma

Bleeding Disorders

Cancer

Depression

Diabetes

Heart Disease

High Blood Pressure

Kidney Disease

Mental Illness

Seizures

Stroke

Other:

## HOW MUCH DO YOU CONSUME PER DAY OF:

Water:

Coffee:

Tea:

Soda:

Alcohol:

## DO YOU PREFER:

Warm Drinks

Cold Drinks

Room Temperature Drinks

## DO YOU FIND THAT YOU ARE:

Always Thirsty

Rarely Thirsty

Thirsty for Sips Later in the Day

## TYPICAL EATING HABITS:

Skip Meals

Eat in a Rush

Eat too Fast

Cannot Eat when Anxious

No Desire to Eat

Eat Late at Night

Cannot Eat when Stressed

Excess Hunger

Other:



**WHAT ARE YOUR TYPICAL SLEEPING HABITS?**

Fall Asleep Quickly

Trouble Staying Asleep

Frequent Dreaming

Trouble Falling Asleep

Deep Sleeper

Disturbing Dreams

Difficulty Waking Up

Light Sleeper

Wake at the Same Time Every Night

Hours of Sleep per Night

Other:

**DESCRIBE YOUR ENERGY LEVELS**

High

Low

Normal

Hyperactive

Lethargic

Changes from Day to Day

Other:

**DO YOU HAVE AN AVERSION TO ANY OF THE FOLLOWING:**

Cold

Dampness

Loud Noises

Wind

Heat

Crowds

Other:

**WHAT IS YOUR AVERAGE BODY TEMPERATURE:**

Hot

Cold Feet & Hands

Colder at Night

Cold

Hotter at Night

Hot Joints

Other:

**This is a true and accurate medical history and I understand and accept I AM Designed to Heal's privacy policy and Arbitration Agreement**

Signature:

Date:

