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.

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:

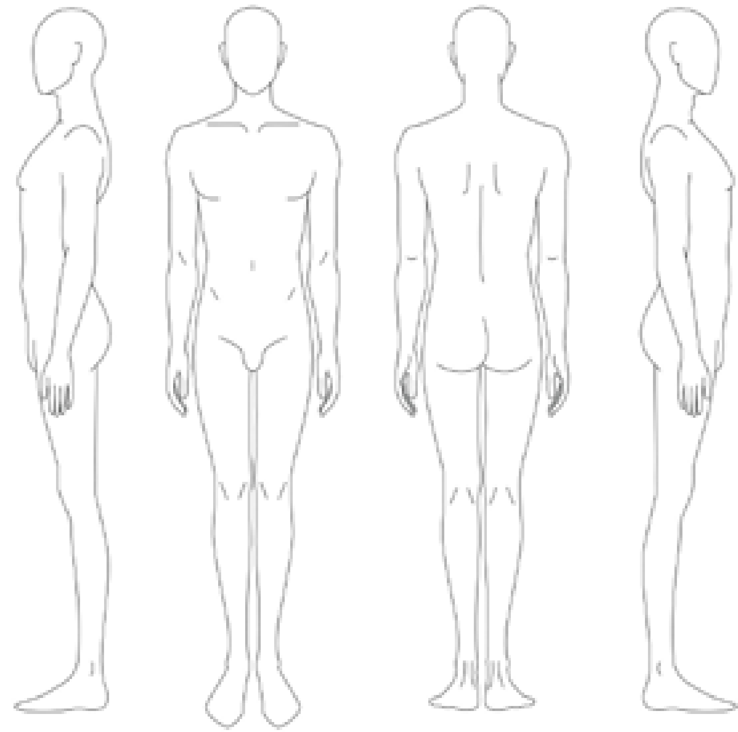
Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopthic remedies that you are taking, including dosage if you know it:

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

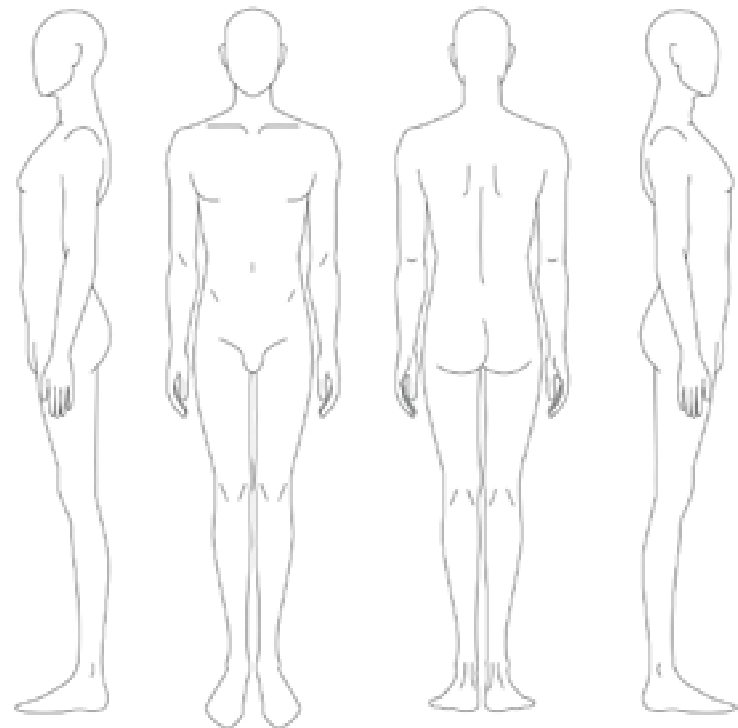
Does the pain get better or worse with:

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
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Does the pain get better or worse with:

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Pressure	- Better	- Worse
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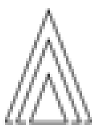
Degree of Pain (please circle 1=Low; 10=High)

1 2 3 4 5 6 7 8 9 10



GENERAL INFORMATION

Anorexia / Bulmia
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
Tonsilitis

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

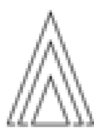
Anaemia
Arteriosclerosis
Easily Bruised
Poor Circulation
Blood Clots

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

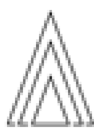
Number of Days of Period

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

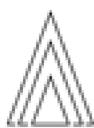
DO YOU FIND THAT YOU ARE:

- 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 YOU 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: