Patient Intake Form		
Name:	DOB:	Date:
Address:	Phone:	
Email:	Weight:	Height:
Emergency Contact (Name/#/Relationship):		
Where did you hear about Vitality Acupuncture?		
Primary Concerns/Reason(s) for Visit: (Include Onset eg. 09/2010, Frequency eg. 2x/wk , Severity eg. 8/10)		
1)		
2)		
3)		
Past Medical History (Include dates of surgeries or diagnosis)		
1)	4)	
2)	5)	
3)	6)	
Familial Medical History: (eg. Heart Disease, Diabetes, Cancer, etc.)		
Mother:	Father:	
Siblings:	Children:	
Medications/Supplements: (Name/Dose/Reason for taking)		
Notes:		

Patient: Practitioner:

Patient Intake Form			
Allergies: (Drug or Substance/Reaction)			
Medical History: (Please Circle)			
AIDS/HIV	Alcoholism	Anemia	Appendicitis
Arthritis	Asthma	Bronchitis	Cancer
Chicken Pox	Colitis	Diabetes	Emphysema
Epilepsy	Gout	Heart Disease	Hepatitis
Hypertension	Hyperthyroid	Hypothyroid	Irritable Bowel
Measles	Mononucleosis	Multiple Sclerosis	Mumps
Pacemaker	Pleurisy	Pneumonia	Rheumatoid Arthritis
Seizures	Stroke	Ulcers	Whooping Cough
Lifestyle/Dietary Information:			
Alcohol (#/wk):	Marijuana:	Other Drug:	Tobacco (#/day):
Exercise (x/wk):	Type:	Soda (#/day):	Coffee/Tea (#/day):
Appetite: Poor/Normal/Excessive/None		Thirst: None/Normal/Very	
Cravings: sweet/salt/sour		Glasses of water (#/day):	
Do you eat regularly?		Servings of Fruit/Veg (#/day):	
Circle the following with respect to CURRENT state of health			
Cardiovascular:			
Chest Pain	Fainting	Fast Hearbeat	Heart Attack
High Blood Pressure	Irregular Heartbeat	Low Blood Pressure	Palpitations
Slow Heartbeat	Varicose Veins	Other:	
Notes:			

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Patient Intake Form			
Gastrointestinal Conditions:			
#of BM/day:	Acid Reflux	Bad Breath	Bloating after Meals
Blood in Stool	Constipation	Diarrhea	Gas
Gurgling Sounds	Hard Stools	Hemorrhoids	Hiccup
Irritable Bowel	Intestinal Cramps	Laxative Use	Loose Stools
Mucus in Stool	Nausea	Rectal Pain	Stomach Cramps
Ulcerative Colitis	Undigested Food in BM	Vomiting	Other:
Conditions of the Head, Eyes, Ears, Nose, and Throat:			
“Floaters” in Vision	Bleeding Gums	Blurred Vision	Cataracts
Clear Throat Often	Concussion (#) ___	Dry Mouth	Earaches
Enlarged Thyroid	Eye Strain	Glasses	Glaucoma
Grinding Teeth	Gum Disease	Headaches	Itchy Eyes
Lumps in Throat	Migraines	Multiple Cavities	Night Blindness
Nose Bleeds	Poor Hearing	Sore Throat	Red Eyes
Ringing in Ears	Soft Teeth	Sore Gums	Sores on Lips/Tongue
Swollen Glands	TMJ Dysfunction	Other:	
Respiratory Conditions:			
Asthma	Chest Oppression	Chronic Cough	Dyspnea Lying Down
Dry Cough	Shortness of Breath	Tightness in Chest	Wheezing
Productive Cough (with A lot of/Sticky/Very Little/Green/Clear/Blood Sputum)			
Conditions Related to Sleep Patterns:			
Hours/Night (#)	Dream Disturbed Sleep	Insomnia	Nightmares
Wake Frequently	Hard to Fall Asleep	Wake Up Tired	Awake During Night (#)
Notes:			

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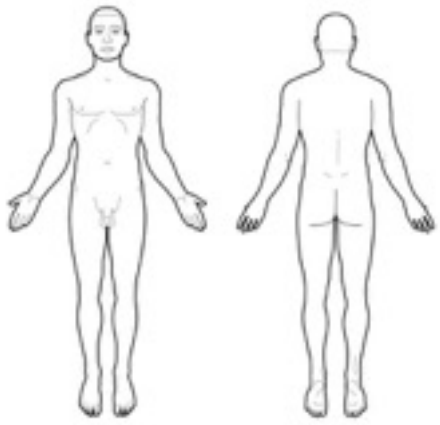
Conditions of the Skin and Hair:			
Acne	Brittle Hair	Dandruff	Dry Skin
Eczema	Fungal Infections	Hair Loss	Hives
Itchy Skin	Oily Skin	Premature Grey Hair	Psoriasis
Shingles	Ulcerations	Other:	
Urinary Conditions:			
Burning Urination	Clear Urine	Cloudy Urine	Copious Urination
Dark Yellow Urine	Bladder Infections	Kidney Infections	Frequent Urination
Light Yellow Urine	Painful Urination	Retention of Urine	Scanty Urination
Urinary Incontinence	Urination at Night	Other:	
Musculoskeletal Conditions: (Show on Diagram)			
Abdominal Pain	Ankle Pain		
Back Pain - Upper	Back Pain - Lower		
Back Pain - Mid	Chest Pain		
Elbow Pain	Finger Pain		
Hand Pain	Hip Pain		
Knee Pain	Leg Pain		
Foot Pain	Neck Pain		
Shoulder Pain	Rib Pain		
Toe Pain	Other:		
Notes:			

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Patient Intake Form			
Neuropsycological Condition:			
ADHD	Anxiety	Depression	Easily Stressed
Seizure	Irritability	Fainting	Numbness
Tingling	Tics/Tremors	Other:	
Reproductive History:			
Male Information			
Erectile Dysfunction	Low/High Libido	STIs:	Prostatitis
Female Information			
Bleeding w/ Intercourse	Pain w/ Intercourse	Headache after Orgasm	Low/High Libido
Number of Pregnancies:		Number of Children (ages):	
Contraceptive Use:		Abnormal Pap Smears	Breast Discharge
STIs	Endometriosis	Ovarian Cysts	Uterine Fibroids
Yeast Infections	Hot Flashes	Vaginal Dryness	Increased Body Hair
PMS Symptoms:		Menstrual History:	
Emotional	Breast Tenderness	Age of 1st Period:	Regular/Irregular
Back Pain	Acne	Cycle Length:	Menses Length:
Headaches	Bloating	Spotting Between Menses	
Cramps	Constipation/Diarrhea	Other:	
Notes:			

Patient: Practitioner:

Consent to Treatment

I, _____, hereby request and CONSENT to treatment utilizing any combination of the following: acupuncture, auricular therapy, cupping, guasha(skin scraping), heat therapy, electroacupuncture, herbal therapy, nutritional counselling, physical manipulations administered at Vitality Acupuncture and Massage.

I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body. Acupuncture attempts to restore physiological body functions, modify or prevent pain perception.

I understand with acupuncture treatment that there are some very slight risks to treatment, including but not limited to: local bruising, minor bleeding, infection, temporary pain and discomfort, fainting, and possible aggravation of symptoms.

I understand that acupuncture has been safely practiced for centuries. I also understand that there are no guarantees concerning its use and effects are given to me and that I am free to discontinue treatment at any time.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned modalities of treatment. I intend this consent form to cover the entire course of treatment for any and all conditions treated at Vitality Acupuncture and Massage.

Cancellation Policy

Twenty four hours notice is required for all cancellations. Failure to cancel will require payment of the full treatment amount. Short notice cancellation will be subject to 50% of the treatment cost. Payment may be required prior to booking your next appointment.

_____ _____

(Patient/Guardian Signature) (Practitioner Signature)

Signed this _____ day of _____, 20_____

Vitality Acupuncture and Massage

1322 102nd Street
North Battleford, SK S9A 1G5

Patient: Practitioner: