COUNTRY HILLS MASSAGE

ACUPUNCTURE AND TCM HISTORY INTAKE FORM

Last Name _____ First Name _____

Address _____ Birthday _____
Street City D/ M/Y

_____Phone (Home)_____(Work)_____(Cel)_____
Province Postal Code

Email Address _____

Occupation _____ Business Phone _____

Emergency Contact _____ Phone _____

Doctor's Name _____ Phone _____

NOW: □ PREGNANT □ PACEMAKER □ HIV DISEASE □ HEPATITIS □ BLOOD TRANSFUSION

FAMILY HISTORY:

□ Abuse □ AIDS □ Alcoholism □ Allergies □ Asthma □ Cancer □ Chemical Dependency □ Diabetes □ Heart Disease □ High Blood Pressure □ Mental Illness □ Respiratory Diseases □ Seizures □ Stroke □ Other _____

YOUR PAST MEDICAL HISTORY/ILLNESSES: □ Other:

□ Aids/HIV □ Alcoholism □ Allergies □ Anemia □ Arthritis □ Asthma □ Auto Immune Disease □ Bleeding Disease □ Breast Cysts □ Bi Polar □ Bronchitis □ Cancer □ Candida (Yeast) □ Chemical Dependency □ Chronic Fatigue Syndrome □ Chronic Lung Disease □ Colitis □ Diabetes □ Eating Disorder □ Fracture □ Glaucoma □ Gall Stones □ Gout □ Headaches □ Heart Disease □ Hepatitis □ Hernia □ Herniated disc □ High Blood Pressure □ High Cholesterol □ Kidney Disease □ Liver Disease □ Low blood pressure □ Migraine □ Mononucleosis □ Multiple Sclerosis □ Mental Illness □ Osteoporosis □ Organ Transplant □ Parkinson's □ Pneumonia □ Prostate problems □ Rheumatic Fever □ Seizures/Epilepsy □ Sexually Transmitted Diseases (STD) □ Stroke □ Substance Abuse/Addiction □ Suicide attempt □ Thyroid Disease □ Tuberculosis □ Ulcers □ Vaccine Reaction □ Whooping Cough

SURGERIES: (Please include dates and if any complications)

1_____ 2 _____
3_____

TRAUMATIC INJURY: (Please include dates and if any complications)

Car accident(s) _____
Fall(s) _____ Other_____

CURRENT MEDICATIONS and ALLERGIES:

HABITS/EXCESSIVE USAGE: (Please tell us how often & how much)

□ alcohol_____ □ cigarettes _____ □ coffee _____ □ exercise_____ □ salt _____ □ sugar _____ □ tea _____ □ water _____ □ other _____ .

CHIEF COMPLAINT / REASON FOR YOUR VISIT:

How and when did this condition begin?_____
Please list your main health concerns you would like to be free of, in order of importance:
1. _____2._____

GENERAL (Please check all that apply to you within the last 3 months)

□ poor appetite □ insomnia □ bleeds easily □ diff loosing/gaining weight □ change in appetite □ hours of sleep _____ □ bruises easily
□ excessive need for sleep □ large appetite □ easy to fall asleep □ chronic fatigue □ chills □ cravings □ heavy sleeper □ lethargy
□ trouble falling asleep □ weight gain □ light sleeper □ fatigue/tired □ hot flashes □ weight loss □ disturbing dreams
□ sudden drop in energy □ tremors/shaking □ sleep walking □ trouble staying asleep □ vertigo □ edema □ weakness □ sleep apnea
□ bitter taste □ poor coordination □ fevers □ dizziness □ headache □ Herbs □ sweating □ Vitamins □ mental fog

Energy level: □ high □ moderate □ low Thirst desires: □ hot □ cold □ room temp. □ no desire
Cold sensations: □ hands □ feet □ back Heat sensations: □ hands □ feet □ solar plexus □ abdomen □ whole body
Stiffness: □ joints □ back □ limbs Intolerance to: □ hot □ cold □ wind □ fan □ A/C
Are you taking: □ Aspirin □ Blood Thinners Do you follow a special diet: □ yes □ no
If so, please explain: _____

SKIN AND HAIR (Please check all that apply to you within the last 3 months)

□ rashes □ eruptions □ change in skin texture □ fungal/yeast infection □ eczema □ discharge □ dandruff skin type: □ dry □ moist □ sores □ pimples/acne □ loss of body hair □ other skin problems: _____ □ ulcers □ bruises □ change in hair □ other hair problems: _____ □ herpes □ itching □ balding □ psoriasis □ hives □ thinning of hair

HEAD, EYES, EARS, NOSE, MOUTH & THROAT(Please check all that apply within the last 3 months)

□ dizziness □ cataract/ □ loss of hearing □ loss of smell □ grind teeth □ dry throat □ migraine ? glaucoma □ discharge
□ good sense of smell □ drooling □ hoarseness Headaches: □ eye pain □ earaches □ nose bleeds □ excess saliva □ recurrent □ frontal
□ twitching □ poor hearing □ allergies □ dry mouth □ sore throat □ temporal □ floaters/spots □ itchiness □ nasal discharge □ gum disease
□ loss of voice □ vertex □ poor vision Ringing in ears: color: □ yellow □ bad breath □ difficulty □ occipital □ blurry vision □ loud □ soft
□ white □ clear □ gum bleeding □ swallowing □ head injury □ night blindness □ high pitch □ green □ gum swelling □ "lump in throat"
□ facial pain □ itchiness □ low pitch amount: □ scanty □ frequent □ facial paralysis □ glasses/contacts □ inflammation □ mod □ heavy
□ ulcers □ tonsillitis □ sinus problems □ red eyes □ tenderness □ thick □ thin □ sores □ freq. sore throat □ heaviness in head □ dry nose
□ dry lips □ taste in mouth other

CARDIOVASCULAR (Please check all that apply to you within the last 3 months)

□ high blood pressure □ chest pain □ difficulty in breathing □ coma □ low blood pressure □ cold hands/feet □ shortness of breath
□ loss of consciousness □ dizziness □ swelling hands/feet □ dream disturbance □ heart pounding □ fainting □ irregular heart beat
□ poor memory □ stifling sensation in chest □ palpitations □ insomnia □ mania/delirium other:_____

RESPIRATORY (Please check all that apply to you within the last 3 months)

□ pneumonia cough: how long? _____ □ shortness of breath □ bronchitis □ dry □ croup □ rapid □ other □ fullness in chest
□ asthma phlegm: □ thin □ thick □ clear difficulty breathing: □ coughing blood □ white □ yellow □ green □ sitting □ lying down
□ wheezing □ tightness in chest □ allergies □ difficulty inhaling or exhaling □ frequent colds □ sinus infection □ post nasal drip
□ frequent sighing □ chronic cough □ sinus congestion □ heaviness in chest □ other chest discomfort

GASTROINTESTINAL (Please check all that apply to you within the last 3 months)

□ food allergies □ taste in mouth □ loose stools □ difficult stools □ tenderness in abdomen □ vomiting □ belching □ bloody/black stools
□ mucus in stools □ fullness in abdomen □ cramping □ bad breath □ ulcers □ hemorrhoids □ burning in abdomen □ gas after meals
□ hiccup □ increased appetite □ hernia □ like/dislike pressure □ abd/stomach pain □ constipation □ poor appetite □ rectal pain
□ like/dislike cold □ nausea □ diarrhea □ hungry-no desire to eat □ rectal bleeding □ like/dislike warmth □ overeat □ mouth sores
□ dry, hard stools □ pain with passing stool □ difficulty swallowing □ tastelessness □ heart burn/reflux □ "nervous stomach" □ fluction ls
□ fatigue after eating □ bulimia □ cravings □ gall stones

GENITO-URINARY (Please check all that apply to you within the last 3 months)

□ burning /painful urine □ poor stream/scanty urine □ diminished sex drive □ discharge color: □ cloudy □ pale □ dribbling urine
□ increased sex drive □ history of kidney stones □ dk yellow □ pink/red □ unable to urinate □ impotency □ history of bladder infections
□ unable to hold urine □ frequent urination □ genital itching □ history of prostate problems □ urgency to urinate □ sexually active ?
□ genital sores/pain □ history of STD □ wakes up to urinate more than once per night How many times?_____

NEUROPHYSIOLOGICAL (Please check all that apply to you within the last 3 months)

□ history of mental illness □ melancholy □ joyful □ tremors/shaking □ depression □ grieving □ giddy □ convulsions □ anxiety
□ easy to anger □ over-thinking □ coma □ easily stressed □ irritability □ talkative □ concussion □ confusion/foggy □ restlessness

□ silent □ paralysis □ lack of clarity □ emotional □ extrovert □ trauma at birth □ moody □ frequent sighing □ introvert □ vaginal delivery □ cesarean □ fear/fright □ over-worried □ poor memory □ considered/attempted suicide □ hyper □ bad-tempered □ seizures □ unable to focus □ sadness □ tics □ panic □ phobia □ frustration □ hopelessness □ feeling stuck □ seeing therapist

MEN'S HEALTH (Please check all that apply to you within the last 3 months)
□ prostate problems □ swellings, lumps and pain in testicles □ discharge from penis □ decreased libido □ cold feeling in genitals □ difficult achieving and maintaining erection □ hernia □ difficult ejaculation □ injury to reproductive organs □ infertility □ painful erections □ currently sexually active □ history of STD □ other:_____.

MUSCULO-SKELETAL (Please check all that apply to you within the last 3 months)
□ face □ jaw □ chest □ epigastric area □ rib cage □ low abdominal □ pelvic □ genitals □ neck □ shoulder □ fingers □ upper back □ mid back □ knee □ lower back □ sacrum/tailbone □ sciatica □ upper limbs □ lower limbs □ feet □ whole body □ bone □ muscle □ joint Rate the pain: Scale 1-10 (10 worst) 1 2 3 4 5 6 7 8 9 10 Please indicate which side is affected: _____ How often is the pain present □ 0-25% □ 26-50% □ 51-75% □ 76-100% of the time Do you often carry heavy objects? □ not often □ often Is/does your pain? : □ fixed □ moves around □ radiates □ sharp □ dull Is the pain □ aggravated by □ alleviated by: □ sitting □ standing □ movement □ pressure □ warmth □ cold □ other:_____ Do you have? □ pain □ swelling □ burning □ weakness □ numbness □ tingling □ arthritis □ clicking □ stiffness □ spasms □ twitching □ shaking □ soreness □ tenderness □ unsteadiness □ tension □ heaviness □ better with movement □ worse with movement □ hernia

GYNECOLOGY AND PREGNANCY (Please check all that apply to you within the last 3 months)
Date of last PAP:_____ Last Menstrual Period:_____ color: □ pale red □ light red □ red □ dark red □ red/purple □ purple □ dk purple □ brown □ pelvic pain □ currently sexually active □ pregnant currently □ # of pregnancies _____ □ # of live births _____ □ no. of miscarriages _____ □ # of abortions_____ □ # of premature birth _____ □ age at first menses □ fibroids □ endometriosis □ length of period_____ □ abd. Bloating/fullness □ spotting between periods clots: □ large □ small □ early menstrual cycle(less 21 days) □ mood change before period □ body change before period □ late menstrual cycle (less than 35 days) Menstrual pain/ cramps: □ before □ during □ after Vaginal discharge: □ odor □ no odor □ watery □ thick □ curdy □ itchy color: □ clear □ white □ yellow □ bloody □ infertility □ pain during intercourse □ irregular menstrual cycle □ days of heavy flow _____ □ uterine prolapsed □ menopause: □ pre □ post □ endometriosis birth control pills: □ age at menopause _____ flow: □ thick □ thin □ vaginal burning/itching type _____ □ history of ovarian cysts amount: □ scanty □ mod □ vaginal pain how long? _____ □ history of uterine problems □ heavy □ very heavy □ genital eruptions □ hormone replacement □ decreased libido □ absent menstruation BREAST (Please check all that apply to you within the last 3 months) □ history of breast disease □ breast tenderness breast discharge: □ clear □ white □ yellow □ green □ breast lumps/masses □ breast fullness/swelling □ black □ blood □ watery □ thin □ thick □ history of breast cancer □ breast pain other:_____

INFERTILITY (Please explain with as much detail as possible)
How long have you been trying to get pregnant? _____
Have you tried any method of assisted reproduction?_____
Any long term exposure to chemicals? _____
Do you keep track of you menstrual cycle? _____
Do you keep your BBT(Basal Body Temperature? _____
Do you test yourself for ovulation?_____
Has your partner been evaluated for infertility?_____
Anything else you would like to tell us?_____

PLEASE READ CAREFULLY BEFORE SIGNING

I, hereby request and consent to the performance of acupuncture and other procedures related to acupuncture necessary including needling, moxibustion, cupping, electro stimulator and other techniques within the scope of the practice of Traditional Chinese Medicine. These procedures will be performed by an acupuncturist, in accordance with the Alberta Acupuncture Regulation. I have had an

opportunity to discuss with the acupuncturist and or with other clinical personnel, the nature and purpose of acupuncture care and it's

procedures.

I have been advised that all insertion needles are individually packaged, pre-sterilized and disposable, therefore the risk of infection is extremely rare. I further understand and have been informed that as with all health care , in the practice of acupuncture, there are some slight risks associated with treatments, including but not limited to, temporary soreness, bruising, blistering, minor bleeding and temporary aggravation of symptoms, nausea and fainting.I understand and acknowledge that withholding or giving false information can lead to improper treatment which the therapist cannot be held liable for.

Patient Confirmation of Consultation with Physician
Section 8[1] of Alberta's Acupuncture Legislation states that acupuncturist shall not undertake the care and treatment of a person unless
[A] that person has already consulted a physician or in the case of dental pathology, a dentist about the condition for which the care and treatment from acupuncturist is being sought
[B]that the person has informed the acupuncturist that a physician or dentist has been consulted about the condition
[C]the patient has completed a patient consultation form.

All information in my file is confidential. Country Hills Massage Therapy will not release any information from my file unless I have signed a release form authorizing them to do so.

CANCELLATION POLICY:
If you are unable to make an appointment, please give Country Hills Massage Therapy 2 hours cancellation notice. You will be responsible for the full amount of your treatment for failure to do so. We thank you in advance for your cooperation.

Signed _____ ***Date*** _____

Therapist _____ ***Date*** _____