



ACUPUNCTURE INTAKE FORM

First Name: _____ Last Name: _____

Preferred Name: _____ Prefix/Title: _____

Cell: _____ Home: _____

Address: _____
(Street) (City, Province) (Postal Code)

Date of Birth: _____ Gender: _____ Sex: M / F
(DD / MM / YYYY)

Alberta Health Number: _____ Guardian: _____

Occupation: _____ Employer: _____

Emergency Contact Phone: _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____

=====

Family Doctor: _____

Family Doctor Phone: _____ Family Doctor Email: _____

Name of referring professional: _____

Referring Prof. Phone: _____ Referring Prof. Email: _____

=====

*Welcome! Please take a few minutes to complete this Acupuncture Intake Form. It's detailed for a reason; the more I know what's going on for you, the better we can develop an effective treatment plan. Please answer as clearly and completely as possible, even if it seems unrelated to your reason for coming in. All information is kept ****confidential**** and will go directly to your chart for the me to view.*

How did you hear about our practice? _____

Were you referred to a specific practitioner? _____

Have you had Acupuncture before?

☐ Yes ☐ No ☐ IMS/dry needling

1. Main Concerns

What brings you to see me today? If more than one reason, please list according to your priority.

Approximately when did you start to see signs of this condition(s)? Was there a related initiating event or trauma?

What seems to make it better?

What seems to make it worse?

What sort of professional care and self care have you tried and did it help?

2. Health History

Please provide details of any hospitalization, including reason and dates:

Any serious illness, including single occurrence, recurring or chronic?

Please list any current medications and supplements.

3. General History**How do you rate your average physical energy level?**

1 2 3 4 5 6 7 8 9 10

How do you rate your average stress level?

1 2 3 4 5 6 7 8 9 10

Please indicate usage & frequency of the following?

- ☐ Coffee _____
- ☐ Tobacco _____
- ☐ Alcohol _____
- ☐ Recreational Drugs _____
- ☐ Pop/Sweets _____

Do you exercise? What and how much?

What do you do for work? How many hours per week? Do you enjoy it?

What do you “love” to do for fun?

4. Body Systems Check-In (check all that are recurrent or problematic)**Head, Eyes, Ears, Nose, Throat**

- | | | |
|--|---|---|
| ☐ Eye strain, fatigue | ☐ Teeth problems | ☐ Nosebleeds |
| ☐ Eye Pain | ☐ TMJ disorder | ☐ Ringing in ears, tinnitus |
| ☐ Red eyes | ☐ Facial pain | ☐ Poor hearing |
| ☐ Itchy eyes | ☐ Gum problems | ☐ Earaches |
| ☐ Blurred vision | ☐ Sores on lips or tongue | ☐ Headaches |
| ☐ Poor night vision | ☐ Dry mouth | ☐ Migraines |
| ☐ Glaucoma | ☐ Sinus problems | ☐ Concussions |
| ☐ Cataracts | ☐ Excessive phlegm, mucous | ☐ Other head-related concern |

Added notes or details on head, eyes, ears, nose, and throat.**Respiratory**

- | | | |
|--|--|--|
| ☐ Shortness of breath | ☐ Allergies | ☐ Wet cough |
| ☐ Tight Chest | ☐ Shallow, incomplete breathing | ☐ Pneumonia history |
| ☐ Asthma, wheezing | ☐ Dry cough | ☐ Other respiratory concern |

Added notes or details on respiratory function.

Cardiovascular

- | | | |
|--|---|---|
| ☐ High blood pressure | ☐ Blood clots | ☐ Sweat easily |
| ☐ Low blood pressure | ☐ Fainting | ☐ Bleed, bruise easily |
| ☐ Rapid heart beat, tachycardia | ☐ Cold hands or feet | ☐ Chest pain |
| ☐ Palpitations, pounding, racing skipping | ☐ Poor circulation | ☐ Night sweats |
| ☐ Other cardiovascular concern | | |

Added notes or details on cardiovascular function.**Gastrointestinal**

- | | | |
|---|--|---|
| ☐ Nausea | ☐ Laxative use | ☐ Vomiting |
| ☐ Food allergies, intolerances | ☐ Intestinal pain, cramping | ☐ Recent weight loss |
| ☐ Acid reflux, heartburn | ☐ Black stools | ☐ Recent weight gain |
| ☐ Strongly prefer cold drinks | ☐ Light-coloured stools | ☐ Excessive gas |
| ☐ Strongly prefer hot drinks | ☐ Bloody stools | ☐ Bloating |
| ☐ Following a diet, eating program | ☐ Mucous in stools | ☐ Bad breath |
| ☐ Diarrhea | ☐ Hemorrhoids | ☐ Low appetite |
| ☐ Constipation | ☐ Anal fissures | ☐ Excessive appetite |

Added notes or details on gastrointestinal function.

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Suite 310, 1918 Kensington Rd. NW, Calgary, Alberta T2N 3R5

Phone: 403-266-2283 Fax: 403-351-1690

5. Pain Assessment

Please describe any acute or chronic injuries:

Are you currently experiencing pain?
☐ Yes

 ☐ No
How would you rate the severity of pain

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Please describe the pain:
☐ Sharp

 ☐ Burning

 ☐ Dull

 ☐ Aching

 ☐ Shooting

 ☐ Tingling

 ☐ Numb
5. Pain Assessment (cont'd)**What relieves the pain:**
☐ Heat
 ☐ Cold
 ☐ Rest
 ☐ Exercise
 ☐ Acupuncture
 ☐ Massage
 ☐ Chiropractic
 ☐ Physiotherapy
What aggravates the pain?

Skin and Hair
☐ Rashes
 ☐ Hives
 ☐ Eczema
 ☐ Psoriasis
 ☐ Acne
 ☐ Itching
 ☐ Excessive or sudden hair loss
☐ Other hair or skin concerns
Added notes or details on skin and hair.

Ensure you check all that apply:

☐ Haemophiliac	☐ Wear a pacemaker	☐ Diabetes
☐ Anemia	☐ Serious heart condition	☐ Anticoagulant medications
☐ Epilepsy	☐ Serious lung condition	☐ Scheduled surgeries

6. Expectations of Care

In order to provide you with the care that you need, it is important to know more about where you are at in your desire to be well, and how you would like to work together:

For your first visit, what are your expectations of the clinic?

6. Expectations of Care (cont'd)**What are your expectations of me for today and ongoing?**

Please describe your lifestyle habits that will support your health:

Please describe your lifestyle habits that will hinder your health:

Please provide any additional comments that you feel are relevant:

What kind of care and direction do you desire from me? (check all that apply)

- | | | |
|--------------------------------------|------------------------------------|-------------------------------------|
| ☐ Perspective | ☐ Feedback | ☐ Tough love |
| ☐ Validation | ☐ Solutions | ☐ Resource |
| ☐ Message | ☐ Plan | ☐ Caring |
| ☐ Energy | ☐ Structure | ☐ Removed |
| ☐ Advice | ☐ Challenge | ☐ Listen |

7. Men's Health History (if you are Female, skip to section 8)**Have you had a recent physical exam?**

- ☐
- Yes
- ☐
- No

Do you have high cholesterol?

- ☐
- Yes
- ☐
- No
- ☐
- Unsure

Have you recently had any prostate conditions?

- ☐
- Yes
- ☐
- No
- ☐
- Unsure

Do you have or have you had any urinary infections or STDs?

- ☐
- Yes
- ☐
- No
- ☐
- Unsure

Have you ever taken testosterone one supplements/drugs?

- ☐
- Yes
- ☐
- No

How would you define your sexual energy?

- ☐
- Above normal
- ☐
- Normal
- ☐
- Below normal

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8. Female Health History (if you are Male, you're done!)**8a. Menstruation History****Age when your period first started?**

Date of first day of last menstruation:

Usual cycle length (day1 - day 1, e.g. 28 days):

Is your cycle:☐ Regular ☐ Irregular - early/too short ☐ Irregular - late/too long ☐ Irregular - all over the map**Is your flow:**☐ Light ☐ Moderate ☐ Heavy**Menses colour:**☐ Fresh red ☐ Scarlet red ☐ Dark red ☐ Pink ☐ Purple ☐ Brown ☐ Black**Menses consistency:**☐ Watery-thin ☐ Thick ☐ Average ☐ Clotty**Do you have menstrual pain?**☐ No ☐ Yes - before ☐ Yes - beginning ☐ Yes - during ☐ Yes - end**Type of menstrual pain:**☐ Cramping ☐ Stabbing ☐ Heavy ☐ Dull ☐ Intermittent**Pain relief with?**☐ Pressure ☐ Heat ☐ Cold ☐ Pain killers ☐ Nothing helps**Do you have pre-menstrual symptoms?**

☐ Bloating	☐ Breast tenderness	☐ Poor sleep
☐ Bowel movement changes	☐ Headache/migraine	☐ Energy increase
☐ Mood changes	☐ Nausea	☐ Energy decrease
☐ Acne	☐ Fatigue	

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8. Female Health History (cont'd) (if you are Male, you're done!)**8b. Ovulation History****Do you have mid-cycle spotting?**☐ No ☐ Yes**Do you have mid-cycle pain?**☐ No ☐ Yes - right side ☐ Yes - left side ☐ Yes - bottom ☐ Yes - abdomen ☐ Yes - low back**Do you ovulate on your own?**☐ Yes ☐ No**Do you notice cervical fluid changes mid-cycle?**☐ No ☐ Unsure ☐ Yes - white ☐ Yes - dry ☐ Yes - clear & stretchy ☐ Yes - watery**Does your energy change around ovulation?**☐ More ☐ Less ☐ No change ☐ Unsure**8c. General Women's Health History****Any vaginal secretions/discharge?**

☐ No	☐ Yes - green	☐ Yes - watery
☐ Yes - white	☐ Yes - pink	☐ Yes - thick
☐ Yes - yellow	☐ Yes - red	☐ Yes - sticky

8c. General Women's Health History (cont'd)**Have you ever had:**

☐ Abnormal pap smear (details): _____

☐ Cervical operation, when: _____

☐ Yeast infections, last one: _____

☐ Bladder infections/UTI (details): _____

☐ Chlamydia (details): _____

☐ PID (details): _____

Have you ever been diagnosed with:

☐ Uterine fibroids	☐ Pelvic Adhesions	☐ Interstitial Cystitis
☐ Endometriosis	☐ Prolapsed Uterus	☐ Pelvic Floor Dysfunction
☐ Polyps	☐ Prolapsed Bladder	
☐ PCOS	☐ Pelvic Abnormalities	

8d. Contraceptive/Sexual History**Frequency of intercourse** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

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8. Female Health History (cont'd) (if you are Male, you're done!)**8d. Contraceptive/Sexual History (cont'd)****Is intercourse painful?**☐ No ☐ Yes**Birth Control: If yes, indicate when and for how long?**

IUD: If yes, indicate when and for how long?

Depo Provera: If yes, indicate when and for how long?

8e. Pregnancy History**Please list your children, including name, gender, year born, age:**

Please list any pregnancies that did not come to term?

Are you pregnant now?☐ Yes ☐ No ☐ Unsure**Please provide any additional comments or concerns:**

Communication**Appointment Notifications and Reminders**

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Email ☐ Email 2 days prior to appointment**Text Message (SMS)**

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

☐ Text Message (SMS) 2 hours prior to appointment**News and Special Promotions**

☐ Yes, I would like to receive clinic updates and health and wellness information from the Vibe team of practitioners. This is usually sent on a monthly basis.

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Acupuncture Intake Form - Consents

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge. - Required

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree. - Required

Cancellation, No Show and Late Arrival Policies

A credit card is required to reserve appointments of 1 hour (or greater) in length.

When an appointment is scheduled, it is reserved exclusively for you. If you cancel or miss the appointment without sufficient notice, it prevents another individual from booking that time slot resulting in lost opportunity for the therapist to provide their service and generate income. In our desire to be effective and fair to all clients, the following policies are honoured:

CANCELLATIONS: A FULL 24-hour advance notice is required when cancelling an appointment. If you are unable to give 24 hours advance notice you will be charged 100% of the booked service fee.

NO SHOWS: All no shows will be charged 100% of the booked service fee.

Phone calls and emails are time stamped therefore notifications delivered in this manner are subject to our Cancellation and No Show policies.

Cancellation and No Show fees will be automatically charged to your credit card.

LATE ARRIVALS: If you arrive late for your scheduled appointment, your appointment will still end at the scheduled time and you will be charged the full fee for the booked service. It is not the duty of the therapist to accommodate missed time and cannot be demanded.

☐ I confirm that I have read, fully understand, agree to the above policy, and agree to pay the fees associated with the service booked. I authorize Vibe Health & Spine to charge my credit card for any treatment that is not cancelled at least 24 hours prior to the booked service. I certify that I am an authorized user of the credit card on file and will not dispute this scheduled transaction with my bank or credit card company as long as the transaction corresponds to the terms indicated in this consent form. - Required

Signature: _____ Date: _____