FALL RIVER
COLLABORATIVE HEALTH CARE

Acupuncture Intake Form

Personal Information

Name: _____
Last Name First Name Middle Initial Pronouns (He/She/They)

DOB: _____
Year Month Day Height Weight

Address: _____
Street City Postal Code

Phone Number: _____
Home Cell Work

Occupation: _____ Employer: _____

Medical Doctor: _____ Health Card Number: _____

Emergency Contact (name and number) _____

How did you hear about our office?
( ) Patient Referral ( ) Road sign ( ) Google search ( ) Social Media ( ) Another Practitioner ( ) Other

If other, how? _____

Are you currently seeing the following?
( ) Physiotherapy ( ) Chiropractic ( ) Osteopath ( ) Personal Trainer ( ) Naturopathic Doctor
( ) Massage Therapist ( ) Other Specialist

If other, who? _____

What brings you in today? _____

When did you begin to see signs of this condition? _____

Health History

Any significant illness, or diagnosis including single occurrence, recurring or chronic?

_____

Please list any current medications, supplements, and herbal remedies:

_____

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General Health

Psychological, Mood and Energy
( ) Fatigue ( ) Anger ( ) Lethargy ( ) Exhausted ( ) Low energy ( ) Jittery ( ) Stress ( ) Anxious ( ) Irritability
( ) Frustration ( ) Overthinking ( ) Worry ( ) Fear ( ) Sadness ( ) Crying ( ) Depression ( ) Mania ( ) ADHD
( ) Bipolar Disorder ( ) Other

If other, explain: _____

How would you describe your day to day? _____

How would you describe your energy levels? _____

Do you experience headaches/migraines?
( ) Yes ( ) No

If yes, where is the location?
( ) Frontal ( ) Occipital ( ) Temporal ( ) Top ( ) Full Head

Headache pain type
( ) Dull ( ) Sharp ( ) Achy ( ) Stabbing ( ) Throbbing ( ) Other

If other, explain: _____

What makes your headaches feel better? _____

What makes them feel worse? _____

Do you experience
( ) Tinnitus ( ) Whooshing ( ) Recurring ear infections ( ) Ear aches ( ) Ringing in ear
( ) Reduced heading ( ) Itching ( ) Wax buildup

Sinus
Do you experience
( ) Nose bleeds ( ) Sinus infections ( ) Hay fever/allergies ( ) Pressure ( ) Congestion ( ) Other

If other, explain: _____

Do you use a neti pot or similar?
( ) Yes ( ) No

Respiratory/Immunology

Do you experience
( ) Wheezing/asthma ( ) Difficulty breathing ( ) Chronic cough ( ) Chest congestion
( ) Coughing/phlegm ( ) Coughing blood ( ) Frequent colds ( ) TB ( ) Other

If other, explain: _____

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Mouth/Oral

Do you experience
( ) Sore throat ( ) Difficulty swallowing ( ) Mouth sores ( ) Bleeding gums ( ) Dry mouth
( ) Excessive thirst ( ) Bad breath ( ) Other

If other, explain: _____

Neurological

Do you experience
( ) Fainting ( ) Dizziness ( ) Poor memory ( ) Seizures ( ) Tremors ( ) Twitches ( ) Lack of coordination
( ) Stroke ( ) Brain fog ( ) Epilepsy ( ) Other

If other, explain: _____

Endocrine

Do you experience
( ) Thyroid Disease ( ) Diabetes ( ) Other

If other, explain: _____

Cardiovascular

Do you experience
( ) Palpitations ( ) Rapid heartbeat ( ) Irregular heartbeat ( ) High blood pressure
( ) Low blood pressure ( ) High cholesterol ( ) Poor circulation ( ) Chest pain/tightness
( ) Poor circulation ( ) Anemia ( ) Cholesterol ( ) Pacemaker ( ) Other

If other, explain: _____

Hair

Do you experience
( ) Hair loss ( ) Thinning ( ) Bald patches ( ) Greying early ( ) Dry/brittle/no luster ( ) Other

If other, explain: _____

Skin

Do you experience
( ) Dryness ( ) Acne ( ) Rash ( ) Itchiness ( ) Eczema ( ) Hives ( ) Scales ( ) Psoriasis ( ) Bruise easily
( ) Other

If other, explain: _____

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Musculoskeletal and pain

Do you experience
( ) Body aches ( ) Stiffness ( ) Weakness ( ) Hyper mobility Arthritis

If you suffer from the following, where are the locations targeted?

_____

Please describe any acute or chronic injuries

_____

Are you currently in pain?
( ) Yes ( ) No

Pain location
( ) Knee ( ) Neck ( ) Back ( ) Elbow ( ) Hip ( ) Wrist ( ) Ankle ( ) Other

If other, explain: _____

Describe the nature of the pain
( ) Sharp ( ) Burning ( ) Dull ( ) Aching ( ) Shooting ( ) Tingling ( ) Numb ( ) Other

If other, explain: _____

What makes it better?
( ) Heat ( ) Cold ( ) Pressure ( ) Sitting ( ) Standing ( ) Laying down ( ) Movement ( ) Other

If other, explain: _____

Temperature/perspiration

Do you experience
( ) Spontaneous sweats ( ) Does not perspire ( ) Night sweats ( ) Hot flashes ( ) Cold hands or feet
( ) Usually feel cold ( ) Usually feels warm ( ) Other

If other, explain: _____

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Sleep

What time do you go to bed? _____

Do you share a bed?
( ) Yes ( ) No

If yes, who do you share a bed with?
( ) Partner ( ) Children ( ) Pets
What time do you usually fall asleep? _____

What time do you usually get up in the morning? _____

How do you describe your sleep quality? _____

Do you experience
( ) Restful sleep ( ) Light sleep ( ) Heavy sleep ( ) Shallow sleep ( ) Restlessness
( ) Difficulty fall asleep ( ) Waking easily ( ) Waking to use the washroom ( ) Other

If other, explain: _____

Do you dream?
( ) Yes ( ) No

If yes, explain: _____

Digestion

Do you experience
( ) Gas ( ) Bloating ( ) Belching ( ) Acid reflux ( ) Abdominal pain/cramping ( ) Nausea ( ) Vomiting
( ) Feeling of fullness ( ) Flatulence

How would you describe your appetite?
( ) Poor ( ) Ravenous ( ) Uninterested ( ) Eats because you have to ( ) Other

If other, explain: _____

Do you have any pain after eating?
( ) Yes ( ) No

If yes, explain: _____

Dietary preference
( ) Omnivore ( ) Vegetarian ( ) Pescatarian ( ) Vegan ( ) Gluten free

Do you have any eating philosophy or plan followed? _____

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List any food allergies/sensitivities: _____

Do you drink alcohol?
( ) Yes ( ) No

If yes, how much and how often? _____

Do you smoke? (including marijuana and cigars)
( ) Yes ( ) No

If yes, how much and how often? _____

How often do you have a bowel movement and what time of day? _____

Bowel movement consistency
( ) Well formed ( ) Easy to pass ( ) Dry ( ) Feel empty ( ) Thin ( ) Pebble like ( ) Loose or soft
( ) Alternating loose/constipation ( ) Blood in stool ( ) With mucus ( ) Urgency

Bowel movement colour
( ) Brown ( ) Green ( ) Grey ( ) Dark brown ( ) Coffee grounds appearance ( ) Other

If other, explain: _____

Do you experience
( ) Rectal pain ( ) Diarrhea ( ) Constipation ( ) Burning ( ) Accidents ( ) Strong odor ( ) Other

If other, explain: _____

Urological

Do you experience
( ) Bladder infections ( ) Pain ( ) Burning ( ) Prickling ( ) Urgent urination ( ) Excessive urination
( ) Scanty urination ( ) Frequent urination ( ) Blood in urine ( ) Wake up to urinate ( ) Kidney stones
( ) Other

If other, explain: _____

Colour of urine
( ) Dark ( ) Light ( ) Strong odor ( ) Sinks or separates in bowl ( ) Varies ( ) Other

If other, explain: _____

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How often do you go? _____

Gynaecology (women)

Date of first day of last period: _____

If you are post menopause how long were your periods and how were your cycles?

_____

If your flow
( ) Light ( ) Moderate ( ) Heavy

Menses' colour
( ) Fresh red ( ) Scarlet red ( ) Dark red ( ) Pink ( ) Purple ( ) Brown ( ) Other

If other, explain: _____

Menses' consistency
( ) Watery-thin ( ) Thick ( ) Average ( ) Clotty ( ) Other

If other, explain: _____

Do you experience menstrual pain?
( ) Yes ( ) No

Type of menstrual pain
( ) Cramping ( ) Stabbing ( ) Heavy ( ) Dull ( ) Intermittent ( ) Other

If other, explain: _____

What relieves menstrual pain?
( ) Pressure ( ) Heat ( ) Cold ( ) Pain killers ( ) Nothing helps ( ) Other

If other, explain: _____

Do you have pre-menstrual symptoms?
( ) Bloating ( ) Bowel movement changes ( ) Mood changes ( ) Acne ( ) Breast tenderness
( ) Headache/migraine ( ) Nausea ( ) Fatigue ( ) Poor sleep ( ) Energy increase ( ) Energy decrease
( ) Other

If other, explain: _____

Have you had a hysterectomy, please give details.

_____

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Ovulation

Do you have mid-cycle spotting?
( ) Yes ( ) No

Do you have mid-cycle pain?
( ) Yes ( ) No

Do you ovulate on your own?
( ) Yes ( ) No

Do you notice fluid changes mid-cycle?
( ) No ( ) Yes-white ( ) Yes-dry ( ) Yes-clear and stretchy ( ) Yes-watery ( ) Undure

Any vaginal secretions/discharge
( ) No ( ) Yes ( ) White ( ) Yellow ( ) Green pink ( ) Red ( ) Watery ( ) Thick ( ) Sticky

Have you ever been diagnosed with
( ) Endometriosis ( ) PCOS

Do you have history of yeast infections?
( ) Yes ( ) No

Do you take birth control?
( ) Yes ( ) No

If yes, for how long? _____

Do you have an IUD?
( ) Yes ( ) No

If yes, for how long? _____

Do you have Depo Provera?
( ) Yes ( ) No

If yes, for how long? _____

Please list number of kids and years born: _____

Natural birth or c-section? _____

Were any of your births traumatic? _____

Have you had any miscarriages? _____

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Are you currently pregnant?
( ) Yes ( ) No ( ) Unsure

Menopause
( ) Pre-menopause ( ) Menopause

If menopause, please describe your symptoms: _____

Please provide any additional comments that you feel your acupuncturist should know.

_____