FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE
361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Acupuncture Intake Form

Date: _____

First Name: _____ Last Name:_____
Birthdate: _____
Email: _____
Address: _____
Preferred Phone: _____Alt Phone: _____
Emergency Contact Name and Number:_____
Occupation: _____ Referred by: _____
Primary Care Doctor: _____

Chief Complaint _____

Secondary Complaint _____

When did it start? _____

Past Medical History (Include Dates when applicable)

Significant Illness (Please Circle): Cancer Diabetes High Blood Pressure Heart Disease Hepatitis HIV/AIDS Rheumatic Fever Thyroid Disease Seizures

Surgeries: _____
_____
Significant Trauma (auto, accidents, falls, etc.) _____
_____
Allergies (drugs, chemicals, foods): _____
_____
Medicines taken within the last 2 months (include vitamins, herbal supplements, etc.): _____
_____
_____

Exercise: _____
Stress: _____

Habits (Please Circle): Cigarettes Coffee Tea Alcohol Sugar Salt Drugs:_____
Other:_____

Family Medical History (Please Circle) Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma Allergies Alcoholism Other: _____

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General (Please Circle)

Poor Appetite	Heavy Appetite	Poor Sleep	Heavy Sleep
Insomnia	Fatigue	Tremors	Vertigo
Cold Hands	Cold Feet	Cold Back	Cold Abdomen
Fevers	Chills/Feeling Cold	Night Sweats	Sweat Easily
Cravings	Localized Weakness	Poor Coordination	Change in Appetite
Sudden Energy Drop @ _____(time)		Peculiar Tastes or Smells _____	
Strong Thirst (hot/cold drinks)_____		Bleed or Bruise Easily_____	

Skin and Hair (Please Circle)

Rashes	Ulcerations	Hives	Itching
Eczema	Pimples	Dandruff	Loss of Hair
Changes in Hair/Skin_____		Other Hair/Skin Problems:_____	

Head, Eyes, Ears, Nose, Throat (Please Circle)

Dizziness	Concussions	Migraines	Glasses
Eye Strain	Eye Pain	See "Floaters"	Night Blindness
Colour-blindness	Cataracts	Blurry Vision	Earaches
Ringing in ears	Poor Hearing	Nose Bleeds	Sinus Problems
Mucus	Dry Throat	Dry Mouth	Copious Saliva
Teeth Problems	Jaw Clicks	Grinding Teeth	Facial Pain
Gum Problems	Spots in Eyes	Recurrent Sore Throat	
Mouth/Lips Sore	Headaches	Other Head/Neck Problems_____	

Cardiovascular (Please Circle)

High Blood Pressure	Low Blood Pressure	Chest Pain	Irregular Heartbeat
Dizziness	Fainting	Cold Hands/Feet	Warm Hands/Feet
Swollen Hands/Feet	Blood Clots	Stroke	Difficulty Breathing

Respiratory (Please Circle)

Cough	Coughing Blood	Asthma	Bronchitis
Pneumonia	Difficulty Breathing When Laying Down		Tight Chest
Production of Phlegm (what colour?): _____			

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Digestion (Please Circle)

Nausea	Acid Reflux	Vomiting	Belching
Gas	Black Stools	Bad Breath	Rectal Pain
Hemorrhoids	Constipation	Water Stool	Sensitive Abdomen
Pain or Cramps	Laxative Use	IBS	
Bowel Movements:	Frequency:_____	Texture/Form:_____	
	Blood?:_____	Mucus?:_____	

Genito-Urinary (Please Circle)

Painful Urination	Frequent Urination	Urgent Urination	Blood in Urine
Unable to Hold Urine	Kidney Stones		

Wake up to Urinate _____ times a night at _____(time)

Women's Health (Please Circle)

Number of Pregnancies:_____	Age at First Menses___		Flow: Heavy or Light
Number of Births_____	Period (days) _____		Cycle Every ____ Days
Last PAP:_____	Vaginal Discharge	Clots	PMS
Menopause	Breast Lumps	Miscarriages	Birth Control Type_____

Any Discomforts or difficulties you would like to discuss? _____
_____

Musculoskeletal (Please Circle)

Neck Pain Back Pain (where)_____ Muscle Pains (where)_____
Joint pain (where)_____ Other joint or bone problems_____

Neuropsychological (Please Circle)

Seizures	Areas of Numbness	Poor Memory	Concussion
Depression	Anxiety	Easily Angered	Easily Stressed

Any treatment for emotional issues?: _____
_____
Other neurological or emotional issues? _____
_____

Signature: _____ Date: _____
Signature of Practitioner: _____

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Acupuncture Consent Form

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including electroacupuncture by an authorized Acupuncture provider in the clinic.

I understand and am informed that the practice of acupuncture has some risks to treatment, including, but not limited to:

Bleeding or bruising;

Pain during treatment may occur;

Existing symptoms can get worse after treatment. You should tell your acupuncture provider about this, but it is usually a good sign;

Fainting can occur in certain patients, particularly at the first treatment;

Possible perforations of internal organs;

Stuck or bent needle;

Infection.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the acupuncture provider to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncture provider to exercise judgment during the course of treatment in my best interest, based on the findings during assessment. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N. B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

_____ _____ _____

Name of Client (Legal Guardian) Signature of Client Date

_____ _____

Witness Signature of Witness