HEALING FROM THE ROOT

INTAKE-FORM

Patient Name_______________________________ Birth date ____/____/____ M / F circle one
Address_______________________________ City_____________ Prov______ Postal Code__________
Phone (Home)(___)_______________ (Work)(___)_______________ (Cell)(___)_______________
E-mail ______________________________________Referred by_________________________
Employer_______________________________ Occupation_______________________________

Reason for seeking treatment____
_______________________________ ***Date symptom(s) started*** ___________________
Do you have insurance that covers acupuncture? Yes_______ No_______

If applicable:

Circle area(s) of current pain: Head, Neck, Jaw, Shoulder, Arm, Elbow, Wrist, Hand, Upper Back, Lower Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other___________________________
Circle your pain level: **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

How often are your symptoms present? Constantly__ Frequently__ Intermittently__ Occasionally___
Describe your current health condition? Good___ Fair___ Poor___ Chronically ill___
Can you perform all your daily activities? Yes, all activities___ Some activities___ Not at all___
Are you currently under the care of a physician? No____ Yes____
What treatments, if any, have you received for the condition you've come to us for?
(surgery,medications, chiropractic, naturopathic, etc.)
____
____

Please check the appropriate boxes:

Past / Present

____ ____ Alcohol/tobacco/drug Dependence
____ ____ Abnormal menstruation
____ ____ Allergies
____ ____ Angina
____ ____ Arthritis/rheumatoid arthritis
____ ____ Artificial joints
____ ____ Asthma
____ ____ Blood disorder
____ ____ Breast lumps
____ ____ Cancer/tumor
____ ____ Convulsions/seizures
____ ____ Diabetes
____ ____ Diarrhea/constipation
____ ____ Excessive thirst
____ ____ Fainting or dizziness
____ ____ Rapid weight gain/loss

Past / Present

____ ____ Frequent urination
____ ____ Headache
____ ____ Heart attack
____ ____ Heartburn/Indigestion
____ ____ High blood pressure
____ ____ Hospitalizations
____ ____ Surgical procedures
____
____ ____ Kidney disease
____ ____ Liver problems
____ ____ Pacemaker
____ ____ Painful menstruation
____ ____ Palpitation/arrhythmia
____ ____ Peptic ulcer
____ ____ PMS
____ ____ Pregnancy
If pregnant, how many months along

Past / Present

____ ____ Sinusitis
____ ____ Stroke
____ ____ Thyroid
____ ____ Medications
____
____
____
____ ____ Other: ____
____

If a family member has had any of the following circle all that apply:

Arthritis / Lupus / Cancer
Heart Disease / Hypertension
Mental–Emotional Concerns

PLEASE READ AND SIGN IF YOU WISH TO BE TREATED WITH ACUPUNCTURE & TRADITIONAL CHINESE HERBAL MEDICINE.
I, the undersigned, fully understand that no therapeutic treatment, including these, can carry with it any stated or implied guarantee of success. I also understand that these treatments may produce some slight bruising and I release Julian Jones, R.TCMP, R.Ac from responsibility in the event that that should occur.

Patient Signature: ____ Date: __________________