BETA
WELLNESS CENTRE

Acupuncture Intake Form

Today's Date_____
DD / MM / YY

Please complete and return to front desk or e-mail back

Personal Information

Name:_____

Age:_____ Birth Date:____/____/____ Gender:_____

Address:_____

City:_____State:_____Zip:_____

Phone (Mobile):_____

Alternate Phone:_____

Email Address:_____

Occupation:_____

Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact:_____Phone:_____

Main Complaint

Please identify your major health concerns

1. _____

   _____

   How long have you had this problem? _____
2. _____

   _____

   How long have you had this problem? _____
3. _____

   _____

   How long have you had this problem? _____

- Have you been given a diagnosis for these problems? _____
- What other treatments have you tried and what were the outcomes? _____

  _____

  _____

BETA
WELLNESS CENTRE

Personal Medical History *(Please include your childhood history)*

Illnesses:

☐HIV ☐Hepatitis ☐Tuberculosis ☐Cancer ☐Heart disease ☐Stroke ☐High/Low Blood Pressure

☐Diabetes ☐Autoimmune disease ☐Rheumatic Fever ☐Seizures ☐Mental illness ☐Thyroid Disease

☐Kidney or bladder disease ☐Venereal Disease ☐Nursing ☐Pregnant (or planning to be)

☐Other:

_____

_____

Surgeries:

_____

_____

_____

Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.) _____

_____

Do you have a history of current or past infectious disease? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Medications/Supplements (photocopying available)**:**

_____

_____

_____

Allergies/Sensitivities:

Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to.

_____

_____

_____

_____

BETA
WELLNESS CENTRE

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Gynecology

- _____ Age of Menses
- _____ Duration of Menses
- _____ Date of Last Menses
- _____ # of Pregnancies
- _____ # of Births
- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

Musculo-Skeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain with Weather Changes
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Pain with Activity
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Pain After Waking

PAYMENT POLICY

Payment is due in full at the end of your visit for any applicable visit fees.

Please ensure the information that you provide is accurate and complete. If, in the future, the health status that you described above changes, please inform your therapist so they may modify treatment as needed.

All information collected on this Intake form is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment.

_____ _____

(Signature of Patient, Parent or Legal Guardian) (Date)