Colwood Back to Back
Acupuncture and Traditional Chinese Medicine
New Patient Intake Form
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Patient Information		
First Name:	Last Name:	Email:
Date of Birth: / /	Gender:	Identified Gender:
Contact Information		Pronouns:
Phone #:	Address:	Province: Postal Code:
General Information	Reminder: ☐ E-mail ☐ Text ☐ Phone Call	
Emergency Contact:	Phone #:	Relationship:
Occupation:	Family DR/GP:	DR/GP Phone #:

Please list any **medications** or **supplements** you are taking and **dosage**:

_____
_____
_____
_____

Please list any **allergies:** (and reactions if applicable)

_____
_____
_____

When was your last **physical/examination** from a GP or Naturopathic Dr?

_____
_____
_____

Please list any previous **injuries**, **illnesses**, or **surgeries**:

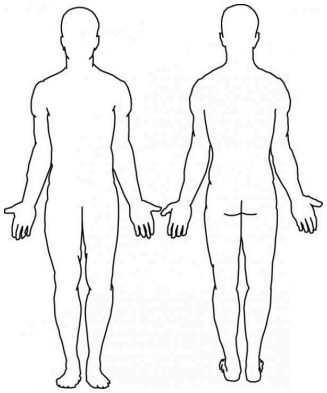
_____
_____
_____

Please list your reason for todays visit:

_____
_____
_____

Pain/Discomfort N/A ☐

Please circle any areas of pain or discomfort:



Rate your pain on a scale of 1-10: _____

Which Quality(ies) Best Describe your pain/discomfort?

☐ Stabbing	☐ Distending/Tight	☐ Sharp	☐ Dull
☐ Fixed	☐ Moving	☐ Intermittent	☐ Constant
☐ Aching	☐ Better w/ heat	☐ Better w/ cold	☐ Swollen
☐ Stiffness	☐ Heaviness	☐ Changes with weather	

Other information regarding pain or discomfort:

_____
_____
_____

Health Conditions: Please check conditions you have, or have had in the past (x) N/A ☐

☐ Hypertension	☐ Angina	☐ Chest pain
☐ Stroke	☐ Epilepsy	☐ Pacemaker
☐ Irregular heart beat	☐ Kidney Disease	☐ Arthritis
☐ Osteoporosis	☐ Clotting disorder	☐ Unexplained weight loss

☐ Other condition not listed:

_____
_____
_____

__ Infectious or communicable disease diagnosis:

_____
_____
_____

In the following sections please indicate (1) mild occurrence (2) medium occurrence/severity (3) frequent occurence/severity

General Symptoms

☐ Weight loss	☐ Weight gain	☐ Fever	☐ Chills	☐ Palpitations
☐ Daytime sweating	☐ Extreme thirst	☐ Thirst with no desire to drink		☐ Edema/swelling
☐ Numbness/tingling	☐ Paralysis	☐ Tremors	☐ Seizures	☐ Fainting

Respiratory Nose/Mouth/Throat

- [ ] Nose bleeds
- [ ] Nasal discharge
- [ ] Frequent sneezing
- [ ] Change in sense of smell
- [ ] Sore throat
- [ ] Hoarse voice
- [ ] Difficulty swallowing
- [ ] Toothache
- [ ] Bleeding gums
- [ ] Mouth/tongue ulcers
- [ ] Jaw pain
- [ ] Dry cracked lips
- [ ] Chronic cough
- [ ] Acute cough
- [ ] Tightness in chest
- [ ] Frequent colds
- [ ] Dry cough
- [ ] Coughing up phlegm
- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] Asthma/Wheezing
- [ ] Nasal Polyps
- [ ] Sinus congestion

Headaches Frequency_____ Duration____ N/A [ ]

- [ ] Chronic
- [ ] Cluster
- [ ] Tension
- [ ] Sporadic
- [ ] Migraine
- [ ] Frontal
- [ ] Sinus
- [ ] Vertex
- [ ] Occipital
- [ ] Dull
- [ ] Fixed
- [ ] Empty
- [ ] Heavy
- [ ] Rebound
- [ ] Nausea
- [ ] Dizziness
- [ ] Tightly bound
- [ ] Pounding

Eyes and Ears

- [ ] Red eyes
- [ ] Dry eyes
- [ ] Ringing Ears (Tinnitus)
- [ ] Difficulty Hearing
- [ ] Itchy Eyes
- [ ] Blurred vision
- [ ] Vertigo
- [ ] Pressure
- [ ] Visual spots
- [ ] Pain
- [ ] Ear discharge

Digestion/Gastrointestinal

- [ ] Acid Reflux
- [ ] IBS
- [ ] Intestinal Gas/Bloating
- [ ] Nausea
- [ ] Vomiting
- [ ] Abdominal pain
- [ ] Bad breath
- [ ] Diarrhea
- [ ] Gas/Belching
- [ ] Indigestion
- [ ] Heartburn
- [ ] Constipation
- [ ] Decreased appetite
- [ ] Increased appetite
- [ ] Fatigue after eating
- [ ] Dry mouth
- [ ] Alternating constipation/diarrhea
- [ ] Preference for cold drinks
- [ ] Preference for warm drinks
- [ ] Bloody/Black stools
- [ ] Stomach pain
- [ ] Hemorrhoids

Penile Reproductive Health

- [ ] Impotence
- [ ] Prostate hypertrophy
- [ ] Premature ejaculation
- [ ] Seminal emissions

Urinary/Renal

- [ ] Painful urination
- [ ] Difficult urination
- [ ] Frequent daytime urination
- [ ] Incontinence
- [ ] Cloudy urine
- [ ] Bloody urine
- [ ] Frequent nighttime urination
- [ ] Low libido
- [ ] Genital pain
- [ ] Genital itch
- [ ] Genital dryness
- [ ] High libido
- [ ] Genital lesions
- [ ] Genital discharge
- [ ] UTI
- [ ] STD

Mental/Emotional

- [ ] Stress
- [ ] Depression
- [ ] Poor memory
- [ ] Excessive worry
- [ ] Fearful
- [ ] Easily irritated
- [ ] Mood swings
- [ ] Anxiety
- [ ] Frustration/Anger
- [ ] Easy or uncontrolled excitability
- [ ] Nervousness
- [ ] Easily frightened
- [ ] Difficulty processing emotions
- [ ] Holding grudges

Sleep Duration of Sleep (hours/night) _____

- [ ] Insomnia
- [ ] Night sweats
- [ ] Tired upon waking
- [ ] Restless sleep
- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Night time urination
- [ ] Vivid dreams
- [ ] Itchy skin while falling asleep
- [ ] Frequent dreams
- [ ] Excessive sleep

Do you wake up at the same time every night? [ ] yes [ ] no time _____

Uterine/Vaginal Reproductive Health/Menstruation N/A [ ]

- [ ] Vaginal discharge
- [ ] Nipple discharge
- [ ] Premenstrual mood fluctuation
- [ ] Uterine fibroids
- [ ] Breast swelling during/before cycle
- [ ] Dry vaginal canal
- [ ] Menstrual dizziness
- [ ] Menstrual Headaches
- [ ] Menstrual diarrhea

Total cycle length ____ Length of bleed____

- [ ] Early Cycle
- [ ] **Menopause**
- [ ] Late Cycle
- [ ] Night sweats
- [ ] Irregular Cycle
- [ ] Hair loss/thinning
- [ ] Painful periods
- [ ] Tinnitus
- [ ] Spotting
- [ ] Flushed cheeks
- [ ] Insomnia

Colour

- [ ] Bright red
- [ ] Dark
- [ ] Pale
- [ ] Brown

Amount

- [ ] Heavy
- [ ] Light
- [ ] Average
- [ ] Amenorrhea

Texture

- [ ] Thick
- [ ] Thin
- [ ] Clotted
- [ ] Watery

Pregnancy and Childbirth N/A ☐

I am currently trying to conceive ☐ I am currently pregnant ☐

I have conceived in the past ☐ Trimester _____

I am not actively trying to conceive ☐ Weeks _____

Due date _____

☐ History of miscarriage

☐ History of infertility

☐ Difficult labour

☐ Previous Cesarean

Pregnancy Symptoms

☐ Morning sickness ☐ Backache ☐ Constipation

☐ Dizziness ☐ Anxiety ☐ Headaches

☐ Swelling ☐ Abdominal Pain ☐ Spotting

Skin

☐ Rashes ☐ Hives ☐ Acne ☐ Dry skin ☐ Oily skin

☐ Easy bruising ☐ Cracked skin ☐ Dry/brittle nails ☐ White spots on nails

Do you consume caffeine? If yes please list amount and frequency

_____
_____
_____

Do you smoke or use chewing tobacco? If yes please list amount and frequency

_____
_____
_____

Do you consume alcohol? If yes please list amount and frequency

_____
_____
_____

Do you use recreational drugs? f yes please list amount and frequency

_____
_____
_____

Do you exercise regularly? If yes please describe activity and amount

_____
_____
_____

Thank you for filling out this confidential intake form.