



BACK & BODY HEALTH

PDF Intake Form Directions

Due to the sensitive nature of the information required, you cannot send these forms via e-mail.

Please print off your intake form, complete it and bring with you to your appointment. Alternatively, you can fax it to us at: 403.245.9030.

If you have any questions please call us:
Tel: 403.209.BACK (2225)



BACK & BODY HEALTH

ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE

PERSONAL INFORMATION

Name:		Today's Date (mm/dd/yyyy):	
Date of Birth (mm/dd/yyyy):	Age:	Gender:	Female Male
Address:			
City:	Province:	Postal Code:	
Home Phone:	Business Phone:		
Spouse / Partner:	Children:	Yes	No
Your Occupation:	Employer:		

In case of emergency, whom should we notify?	
Relation to you?	Contact Number:

Extended Health Care Company:	Policy Number:
Family Doctor:	

How did you hear about our office:	Doctor	Health Care Prof.	Friend	Phone Book	Sign	Internet
Other:	If you chose friend who can we thank?					

REASON FOR APPOINTMENT

What is your chief complaint?

Is your condition due to:	Accident	Illness	Other:
Did your accident occur while you were at work?	Yes	No	When?
Where you involved in an automobile accident?	Yes	No	When?
When did it begin (Date)?			
Describe what caused it:			
What makes it better?		What makes it worse?	
Is it getting worse?	Yes	No	Does it interfere with: Work Sleep Daily Routine Other
Explain:			
Who have you consulted in regards to your present problems?			
Secondary complaints:			
Previous Medical Care:			
Operations (please indicate all surgeries, type and year):			

TREATMENT FOR OTHER CONDITIONS

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HEALTH HISTORY

Name:	Today's Date (mm/dd/yyyy):
Please check the appropriate box for any of the following symptoms that you now have or have had previously.	
*** IF THE SYMPTOM IS NOT APPLICABLE TO YOU, PLEASE LEAVE BLANK ***	

PERSONAL

A.I.D.S./HIV	Gallbladder Disease	Nervous Breakdown
Alcoholism	Glaucoma	Pacemaker
Allergies	Gonorrhea / Syphilis	Pleurisy
Anemia	Hay Fever	Pneumonia
Arthritis	Heart Disease	Polio / Meningitis
Asthma	Heart Trouble	Rectal Disease
Bladder Disease	Hepatitis	Rheumatic Fever
Boils / Infections	High Blood Pressure	Scarlet Fever
Cancer	Jaundice	Scoliosis
Diabetes	Kidney Disease	Stroke
Drug Problem	Mental Disorder	TB / Angina
Epilepsy	Migraines	Ulcers
Food / Drug Poisoning	Miscarriage	
Bladder Disease	Nephritis	
Females: Are you pregnant?	Yes	No
Other:		

FAMILY HISTORY

Is there any family disease tendency of which you are aware? If so, please list below:

INJURIES

Broken Bones	Sprains
Concussion or head injury	Loss of consciousness
Dislocations	
Other:	

CURRENT MEDICATIONS (Include name of medication, what you take it for, how long you have been taking it)

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SUPPLEMENTS (Include any vitamins or herbal products)

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LIFESTYLE

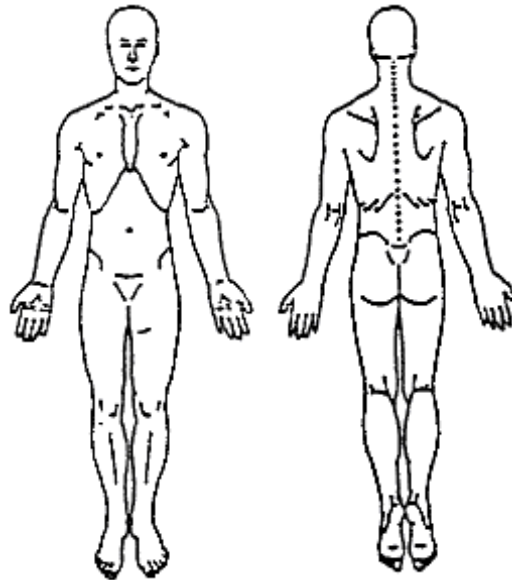
Is your living environment:	Dry _____	Damp _____			
Do you have any preference for the following flavors:	Spicy _____	Sour _____	Sweet _____	Salty _____	Greasy _____
Do you drink:	Coffee (_____ cups/day)	Cold drinks _____	Warm drinks _____		
Do you use:	Cigarettes (_____ pkgs/day)	Alcohol _____	Recreational drugs _____		
Are you an ex-smoker?	Yes _____	No _____	If yes, how long ago did you quit? _____		
What are your major causes of stress? _____					
Are you frequently in a state of:	Fear _____	Worry _____	Anger _____	Sadness/depression _____	Anxiety _____

WHAT DO YOU DO FOR EXERCISE (please include type and frequency)

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DIAGRAM

Please indicate on the following diagram where you are experiencing pain



CONSENT FOR ACUPUNCTURE / TRADITIONAL CHINESE MEDICINE CARE

Advisory Regarding Insurance Coverage, Advice and Care of Medical Physician

I, _____, am aware of both the benefits and risks of Acupuncture Treatment. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I realize that Acupuncture care may/may not be covered at this time by Alberta Health Care or my insurance companies and I am advised to speak with my insurance agent. I am hereby advised to consult with my primary care Medical Physician, on medical issues and that Acupuncture, Traditional Chinese Medicine or Alternative care is not substituting for appropriate medical advice and/or care from a Medical Doctor.

Date:	Date:
Signature:	Witness:
Printed Name:	Relation to Patient: