ANDREA LAMONT

ACUPUNCTURE & HERBAL MEDICINE

ACUPUNCTURE INTAKE FORM

Please note that all information is strictly confidential

First name: _____ Last name: _____

Address: _____ City/Postal Code: _____

Email Address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____

Marital Status: _____ No. of Children: _____

Occupation: _____ Primary Physician: _____

Emergency Contact: _____ Phone #: _____

Who should we thank for referring you to this office: _____

Have you received acupuncture before, and if so, when?: _____

Reason for Today's Visit: _____

_____

_____

How, when and where did this condition begin?: _____

_____

_____

What types of treatments have you tried, if any?: _____

_____

What makes it better?: _____

What makes it worse?: _____

Please list any other health problems you would like to address in order of importance:_____

_____

_____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, Major Accidents (include dates):

_____

_____

_____

_____

_____

Immediate Family Medical History (Mother, Father, Siblings): _____

_____

_____

_____

_____

Current Medications, Vitamins and/or Supplements (include dosages ,brands and what they are for:_____

_____

_____

_____

Do you have any food or drug allergies?: _____

_____

Do you currently have or have you ever had any of the following?:

Anemia Epilepsy Fibromyalgia Arthritis Diabetes Multiple Sclerosis
Emotional Disorder Drug Problem Digestive Disorders Heart Problem
Pacemaker Tuberculosis Cancer Hepatitis HIV Allergies
High Blood Pressure Kidney Disease Osteoporosis Asthma Stroke
Ulcers Thyroid Problem Kidney Stones Gall Stones Alcoholism AIDs

Your Lifestyle:

How do you feel about your diet?: _____

_____

_____

Do you crave any particular foods?: _____

_____

_____

Exercise?: Yes No How often?: _____

What type of exercise?: _____

Sleep: How many hours per night?: _____ Rested in the morning?: _____

Trouble falling asleep?: _____ Trouble staying asleep?: _____

Do you get up to urinate more than once throughout the night?: _____

Work: Do you enjoy your work?: Yes No

How many hours per week do you work?: _____

What are your hobbies?: _____

_____

_____

Please indicate the use and frequency of the following:

	Yes	No	How Much
Coffee:			_____
Tobacco:			_____
Alcohol:			_____
Recreational Drugs:			_____
Water:			_____
Soda Pop:			_____
Milk:			_____
Juice:			_____

Symptom Survey (please check all that apply)

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0	1	2	3	4	low appetite	0	1	2	3	4	ravenous appetite
0	1	2	3	4	loose stools	0	1	2	3	4	heartburn/acid reflux
0	1	2	3	4	gas/abdominal bloating	0	1	2	3	4	mouth sores
0	1	2	3	4	fatigue after eating	0	1	2	3	4	belching or vomiting
0	1	2	3	4	hemorrhoids	0	1	2	3	4	gums bleeding/swollen
0	1	2	3	4	bruise easily	0	1	2	3	4	thirst
0	1	2	3	4	anemia	0	1	2	3	4	bad breath

0	1	2	3	4	abnormal sweating	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	tired after little exertion
0	1	2	3	4	shortness of breath	0	1	2	3	4	general weakness
0	1	2	3	4	cough	0	1	2	3	4	nasal discharge
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	sinus congestion

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0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feel cold often
0	1	2	3	4	low back pain	0	1	2	3	4	swollen ankles
0	1	2	3	4	frequent urination	0	1	2	3	4	poor memory
0	1	2	3	4	urinary incontinence	0	1	2	3	4	hair loss
0	1	2	3	4	ear/hearing problems	0	1	2	3	4	infertility
0	1	2	3	4	early morning diarrhea	low		normal		high	libido

0	1	2	3	4	irritable	0	1	2	3	4	muscle spasms/twitches
0	1	2	3	4	ligament/tendon issues	0	1	2	3	4	numb extremities
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry, irritated eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing

0	1	2	3	4	sigh frequently	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes

0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	recurrent dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	restlessness
0	1	2	3	4	anxiety	0	1	2	3	4	palpitations

0	1	2	3	4	dizzy upon standing	0	1	2	3	4	feeling of heaviness
0	1	2	3	4	see floaters in eyes	0	1	2	3	4	nausea
0	1	2	3	4	heat in palms or soles	0	1	2	3	4	foggy thinking
0	1	2	3	4	afternoon fever	0	1	2	3	4	enlarged lymph nodes
0	1	2	3	4	night sweats	0	1	2	3	4	cloudy urine
0	1	2	3	4	frequently flushed face	0	1	2	3	4	acne

Urination (circle all that apply):

Burning Urgent Scanty Difficult Profuse

Dribbling More than 1x per night

Bowel Movements Frequency: _____

Bowel Movements Consistency (circle all that apply):

Well-Formed Hard Loose Alternates between Constipated and Loose

Do you ever notice any undigested food, blood or mucous?: _____

_____

Are you thirsty?: Yes No If so, do you crave warm or cold drinks?: _____

Upon waking, do you have a bitter taste in your mouth?: _____

Do you find that you 'run' particularly hot or cold?: _____

How is your energy in general?: _____

Do you often get headaches or migraines?: Yes No

How do you feel emotionally right now?: _____

Women Only:

Are you currently pregnant?: Yes No

Are you currently on the birth control pill?: Yes No

# of pregnancies:_____# of live births:_____# of miscarriages:_____# of abortions:_____

How old were you when you first had your period?: _____

Have you experienced menopause?: Yes No When?: _____

If you are experiencing menopausal symptoms, please describe: _____

_____

_____

Vaginal Discharge?: Yes No

Is your period regular?: _____ When was the last day of your last period?: _____

# of days from the start of one period to the start of the next: _____

Average # days of flow: _____ Flow is: Light Normal Heavy

Colour is: Pale Normal Dark Bright Red Brown Purple

Blood Clots: Yes No

Do you get pain or cramps?: Yes No Severe?: Yes No

Nature of pain (circle): Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?:

Water Retention Breast Tenderness/Swelling Depression Irritability Migraines

Insomnia Diarrhea Constipation Nausea Hot Flashes Night Sweats

Other: _____

Men Only:

Date of last prostate checkup: _____ Results: _____

Circle all that apply: Groin Pain Decreased Libido Testicular Pain Impotence

Painful Urination Difficult Urination Dribbling Urination Incontinence

Premature Ejaculation Nocturnal Emissions Increased Libido

Other:_____

_____

_____

Consents and Acknowledgements

I am committed to your health and well-being. While Chinese Medicine is a very thorough health care system, it is not a replacement for western medical treatment, including regular checkups with your primary care physician. I recommend that you consult a physician regarding any condition for which you are seeking acupuncture treatment. We, the undersigned, do affirm that _____ (print patient name) has been advised by Andrea Lamont to consult a physician regarding the conditions for which such patient seeks acupuncture treatment.

Patient Signature: _____ **Date:**_____

Practitioner Signature: _____ **Date:**_____

I consent to acupuncture treatment and other procedures associated with Traditional Oriental Medicine. I have discussed the nature of my treatment with my practitioner.
I understand that methods of treatment may include but are not limited to: acupuncture, massage, moxibustion, gua sha, cupping, electric stimulation, and Chinese herbal medicine.
I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include pneumothorax and organ puncture. Slight superficial burns are a possible side effect of moxibustion.

Patient Signature: _____ **Date:** _____

I acknowledge that if I do not give 24 hours notice for cancellation of an appointment, I will be charged a full fee for the missed appointment.

Patient Signature: _____ **Date:** _____