Ocean Wellness

Yasmin Devji. Registration # 02571
200-1401 Lonsdale Ave, North Vancouver, BC. V7M 2H9
PH: 604-986-9355. Fax: 604-998-0629. Email: info@oceanwellness.ca

Acupuncture Patient Intake Form

This CONFIDENTIAL questionnaire will help determine the best treatment plan for you. Please fill it out completely.

Personal Information

Name_____Age_____ Birthdate_____Date _____

Home Address_____

City_____ Postal Code_____

Home Phone_____ Work Phone_____E-mail_____

Birthdate_____ If under 18, person responsible for your account_____

Emergency Contact: Name_____ Contact Phone:_____

Family physician_____ Phone #_____

When was the last time you visited your family physician? _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No Did it help you? □ Yes □ No

Other forms of treatments you receive:

□ Physiotherapy □ Massage □ Naturopath □ Chiropractor □ IMS
□ Psychologist □ Fertility Clinic □ Osteopath □ Other _____

Please indicate the use and frequency of the following:

Coffee_____ Soda pop_____Water_____

Alcohol_____ Recreational drugs_____ Tobacco_____

Do you bleed easily? _____
Do you eat 3 meals a day? _____
What time do you go to bed? Do you wake refreshed?_____
Sleeping problems? _____
On a scale of 1 (mild) to 10 (extreme) what is your energy level? _____
Are bowel movements regular? How many times a day/week? _____
Do you suffer more from diarrhoea or constipation? _____
Please list any food, drug, environmental or chemical allergies. _____
Please list foods you avoid and why: _____
Do you have cravings for specific foods? _____
Are you vegetarian? _____
Do you enjoy your job? Is it stressful? _____
Is there stress in your life? _____
Are you active?_____

Initial Visit

Reason for today's visit: _____

Please describe in detail the condition. _____

_____

Are there any symptoms associated with or due to the condition? _____

_____

When did it start? _____

Is there a family history to it? _____

What other forms of treatment have you sought for it? _____

What helps your condition? _____

What aggravates your condition? _____

Have you seen your family physician about it? _____

Family physician's western medical diagnosis: _____

Are you taking any medications for it? _____

What would you like to achieve with acupuncture treatments? _____

Would you like to add any other concerns?_____

Medical History

Please list and give dates of any surgeries or major health incidents (accidents, etc.) in your life.

_____

Have you had any recent surgeries or injuries? When? _____
Do you have any upcoming surgeries? When? _____
If you have been hospitalized for any infectious or serious conditions. When? _____
Have you been diagnosed by your Doctor with any diseases? _____

Please list all prescription or over-the-counter medications you are presently taking:

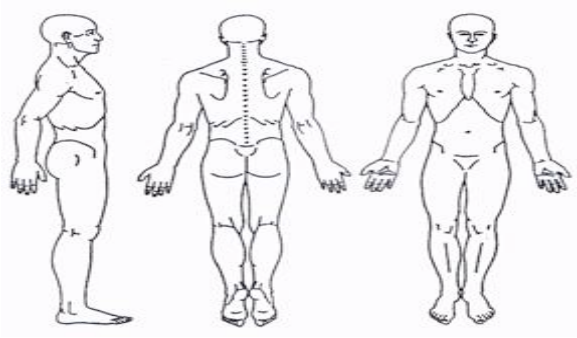
Medication/Vitamins/Supplements/Herbs	Reason

Please indicate, if any of the following pertain to you with a P (past), C (current), F (family history).

	Abdominal Pain		Tumors		Liver problems		Respiratory Condition
	Hyperthyroid		Epilepsy		Low Blood Pressure		Seizures
	Anemia		Headache/Migraine		Lung Disorder		Skin Condition
	Arthritis		Heart Condition		Metal in the body		Hypothyroid
	Asthma		Haemophilia		Nausea or Vomiting		Spinal/Head Injury
	Cancer		Hepatitis		Neurological Condition		Sprain/Fracture
	Contagious Disease		High Blood Pressure		Osteoporosis		Stroke
	Deep Vein Thrombosis		HIV/AIDS		Pace maker		Ulcers
	Diabetes		Infections		Pneumonia		Vision Problems
	Digestive Disturbance		Jaw Problems		Pregnant		Blood Thinners
	Dizziness/Fainting		Kidney problems		Gout		Other

Do You Have Any Pain?

Please indicate where on the diagram.



What is the level of pain on a scale of 1 (mild) to 10 (extreme)? _____
Have you seen your family doctor regarding the pain? _____
What is the western diagnosis? _____
Have you had surgery for the pain? _____
Please describe the pain. Is it a burning pain, tingling pain, dull pain, sharp pain, moving pain, throbbing pain, electrical, stiffness? _____
How long have you had this pain? _____
When did the pain start? _____
What caused it? _____
What makes it better? _____
What makes it worse? _____
Have you tried other treatment therapies for it? _____
If you are taking medications for pain, please list them_____

Symptoms

Please circle if you have any of the following below:				
Heart Disease	Lung Disease	Stomach Problems	Liver Disease	Kidney Problems
Palpitations	Cough	Poor Appetite	Flank Pain/Discomfort	Bladder Problems
Anxiety	Cough with Mucous	Bloating	Irritable/Angry	Low Back Pain
Bipolar	Sputum/Phlegm	Loose Stools/Diarrhea	Stress/Depression	Knee Pain
Sleep Problems	Asthma	Anemia	PTSD/OCD	Foot Pain
ADHD	Allergies	Nausea or Vomiting	Bitter Taste in Mouth	Hair Problems
Psychological Disorder	Pneumonia	Ulcers	PMS	Reproductive Disorder
Canker Sores	Shortness of Breath	Stomach Pain	Visual Spots/Strings	Dislike Cold
Chest Pain/Discomfort	Skin Conditions	Weak Digestion	Often Sighing	Easily Get Cold
Restlessness	Eczema/Psoriasis	Heartburn/Acid Reflux	Often Feeling Rushed	Always Cold
	Recurring Infections	Low Energy	Twitching or Spasms	Sweat at Night
	Weak Immune System	Feeling Heaviness	Feeling of Lump in Throat	
	Sweat Easily/Suddenly		Teeth Grinding	
			Gas	

♀For Women

Age of first period _____
Date of last period _____

Do you have a cycle or no menstruation?_____
Number of days between periods (your cycle). _____
Duration of flow. How many days?_____
Regular or irregular cycle._____
Do you have both ovaries? Any blockages in the ovaries?_____
Do you ovulate regularly?_____

Colour of flow. Pale red. Strawberry red. Dark red. Brown red. Black red._____
Type of flow. Heavy. Light. Spotting throughout. Even flow throughout._____
Any clots? Few or lots?_____
Spotting? Before, during or after?_____

Painful periods?_____
Pain or cramping before, during or after?_____
Pain or cramping, mild, moderate or severe?_____

Premenstrual symptoms? Please list._____
Postmenstrual symptoms? Please list._____
Symptoms during menstruation? Please list._____

PMS symptoms related to menses:

□ Breast Tenderness	□ Insomnia	□ Headache	□ Nausea
□ Discharges	□ Decreased Appetite	□ Constipation	□ Diarrhea
□ PMS	□ Headaches	□ Anxiety	□ Increased Appetite
□ Diarrhea	□ Water Gain	□ Mood Swings	□ Swollen Breasts
□ Other_____			

Have you ever been diagnosed with:

□ Uterine fibroids	□ Fibrocystic breasts	□ Endometriosis	□ Ovarian cysts	□ STD
□ PID	□ Breast Lumps	□ PCOS	□ Other_____	

Are you on any form of birth control? Which kind?_____
When did you stop taking birth control?_____

How many live births?_____
Any abortions? How many?_____
How many miscarriages?_____ At how many weeks did each miscarriage occur?_____
Any reason for miscarriages? _____
Family history of miscarriages?_____

Any vaginal discharges? Please describe._____
Any vaginal sores?_____

Are you in menopause?_____
When was your last period? At what age?_____