



Acupuncture Intake Form

Reflexology/Shiatsu/Tui-Na/Jin Shin Jyutsu/Reiki/Cupping

Today's Date *



Month Day Year

Name *

First Name Last Name

Address *

Street Address

City Province/State

Postal Code

Phone Number *

Area Code Phone Number

Cell Phone Company

If you choose text reminders

Email *

example@example.com

I like appt reminders by: *

Email
Text

I like receiving clinic updates & newsletters: *

Yes, please!
No, thanks

Date of Birth *



Month Day Year

Height *

Weight *

Gender *

Emergency Contact Name *

Emergency Contact Phone Number *

How did you find out about Glow? *

If you were referred by a current patient, please include their name.

Is this a WCB or MVA claim?

WCB
MVA

Briefly tell us what brought you in today:

Have you seen another practitioner for this?

Medical doctor, massage, acupuncture, osteopath, physiotherapist, etc.

Does this interfere with:

Work Sleep
Leisure Other

Current Medical Doctor and contact number:

Current diagnosis, if any:

How long have you had this?

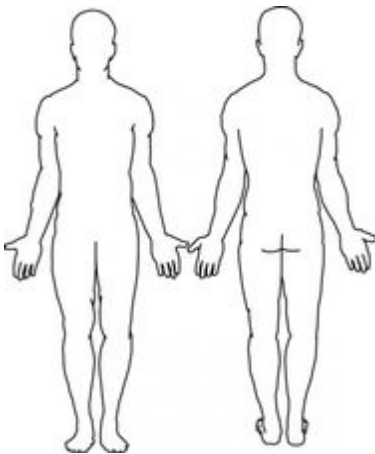
What makes it better or worse?

Is there pain while asleep?

Yes No

Is it aggravated by weather?

Heat Cold Humidity Wind



Select where you have discomfort (circle area or check box):

Head Neck Jaw
Shoulders Chest Abdomen
Ribs Arms Wrists
Hands Upper back Mid back
Low back Hips Legs
Knees Ankles Feet

How is your health?

Excellent Good
Fair Poor

Pain is mostly:

Sharp Numbness Tingling
Dull/Achey Fixed Wandering
Large area Small area Muscle weakness

Please rate your energy level

0 1 2 3 4 5
Very low Very high

Does your energy drop during the day?

Morning Midday
Afternoon Evening

Please rate your stress level

0 1 2 3 4 5 6 7 8 9 10
None Severe

What kind of exercise do you do? And how often?

Please rate your childhood health

If poor, please explain:

0 1 2 3 4 5

Poor

Excellent

Please list any childhood traumas/surgeries/medications:

Please list any implants/artificial joints, et al:

Please list any allergies:

Please list any hospitalizations/surgeries/serious illnesses with their dates:

Please list any family members with serious illnesses:

Please list your medications/supplements with their dose & frequency:

Please list any infectious disease(s):

Do you drink caffeine?

Do you drink alcohol?

Do you smoke?

Heavy

Heavy

Heavy

Moderate

Moderate

Moderate

Rarely

Rarely

Rarely

Any addictions?

If not, please specify:

Do you sleep well?

Yes

No

Hard to fall asleep

Wake up too early

Nightmares/dreams

Wake up for bathroom

Wake during night

Restless

Night sweats

Wake tired

How many hours a night?

Eating habits:

Skip meals	Eat late at night
Eat when stressed	Eat when anxious
Snack	Eat out

Thirst:

Normal	Lack of thirst
Thirst but don't drink	Just sips feel full
Drink a lot	

How many meals a day and when?**How do you like your drinks?**

Hot	Cold	Room temp
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How is your appetite?

Normal	Increased
Decreased	

Has it changed?**How is your digestion?**

Normal	Stomach/ab pain	Heartburn	Bad breath
Acid reflux	Nausea	Vomiting	Hiccups
Belching	Gas	Liver disease	Gallbladder disease
Gallstones	Ulcers	Pain before eating	Pain after eating
Bloating/fullness	Tired after meals	Irritable before meals	Low blood sugar
Rapid weight change	Grease upsets gut	Fat upsets gut	

Do you usually have a taste in your mouth?

Bitter	Metallic	Sweet	Sour
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How are your bowel movements?

Normal (usually 2x/day)	Formed	Small tidbits
Unformed/soft	Hard, dry, strained	Blood/mucus in stool
Black	Undigested food in stool	Diarrhea & constipation
Diarrhea	Urgency to go/pain (dysentery)	Foul smell
Bearing down sensation		

How is your bladder function?

Normal amount	Scanty & yellow	Frequent	Unusual increased vol.
Normal function	Unable to hold urine	Hesitency	Retention
Normal colour	Urgency to go	Dribbling	Difficulty urinating
Blood in urine	Dark & yellow	Turbid & cloudy	Pain before
Pain during	Normal smell	Odourous	Bladder infections
Kidney stones	Edema		

Do you have migraines?

Yes No

If yes, how often?**Do you have a headache now?**

No Yes Temples Forehead Back of head Side of head

Are they aggravated by:Humidity Cold Heat Wind Stress Menses
Concussion Seizures Epilepsy Other**Do you experience any of the following?**Fainting Paralysis Dizziness/vertigo Memory loss
Poor concentration Poor memory Chronic cough Difficulty breathing
Shortness of breath Phlegm Spitting up blood Pain breathing
Shortness lying down Shortness at night Asthma Hayfever**If yes, please explain:****Eyes & vision:**Wear contacts Impaired vision Glaucoma Blurred vision/floaters
Poor night vision Watery eyes Dry eyes Pain/itchy/strained**Ears & hearing:**Normal Hearing aid Deafness Ringing
Ache/itchy Infections Recent hearing loss Other**Mouth & throat:**

Dry mouth Frequent sore throat Sores on mouth/lips Horse/dry throat

Heart/Circulation & Body Temperature:Palpitations/flutter Heart disease High BP Chest pain
Chest tightness Stroke Rheumatic fever Ankle swelling
Anemia Bruise/bleed easily Bleeding disorder Varicose veins
Hemorrhoids Normal body temp Hot body temp Cold body temp
Cold hands/feet Hot hands/feet Heat/cold intolerance Body feels cold

Nose & sinuses:

Frequent colds	Nosebleeds	Stuffiness/nasal drip	Sinus problems
Sensitivity to creams	Sensitivity to oils	Sensitivity to scent	

Skin & Sweating

Dry skin	Itchiness	Hives/rash	Dermatitis
Ulcers	Acne/boils	Eczema/Psoriasis	Inflammation
Change in hair	Change in nails	Sweat very little	Excess sweat
Night sweat	Sweat easily	Night sweats	Sweaty hands/feets

Emotional:

Mood swings	Anxiety/nervousness	Anger/resentment	Frustration
Sadness	Joy	Worry	Fear
Depression	Helplessness		

For Men Only:

Reg prostate exams	Prostate problems	Hernias	Testicular pain
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For Women Only:

Regular periods	Irregular periods	Bleeding between	Birth control
Cramps	Heavy flow	Light flow	Normal flow
No flow	Clots	Bright red flow	Pale red flow
Purple flow	Brown flow	Average consistency	Thick consistency
Thin/watery consist.	No PMS symptoms	PMS	Pain before period
Pain after period	Pain during period	Pain during ovulation	

If pregnant, how far along?

Please list number of pregnancies/births/miscarriages:

Age of 1st period:

Date of last period:

Days of cycle:

Days of flow:

Abnormal vaginal discharge?

Please describe:

Yes No

Vaginal infections?

Please describe:

Yes No

**Ovarian
cysts?**

Please describe:

Yes No

**Breast
fibroids?**

Please describe:

Yes No

If you are menopausal, please describe symptoms:

Risks & Cautions of Treatment:

1. Acupuncture may cause minor bruising or soreness around the needling area. Treatments may cause dizziness, fainting, fatigue if stomach too empty or a temporary worsening of symptoms.
2. Cupping may produce red/purple colour around the cupped area lasting 1-5 days depending on the degree of toxins built up in the muscles.
3. Shiatsu/Tuina Massage may cause temporary fatigue or tiredness as toxins are released from the body.
4. Reflexology relaxes the mind/body and you may feel a bit disoriented after the session or fatigued especially if your body releases a lot of toxins and impurities. These toxins and impurities (waste matter) may put your body through a healing crisis with reactions such as headaches, diarrhea, coldness, nausea and sinus congestion following the session. These reactions are a good sign and usually pass within twenty-four hours.
5. Do not exercise just before or after a treatment.
6. Do not eat a large meal right before or after a treatment. A small meal or snack is appropriate.
7. Hydrate well prior to and a few days following each session.

***Important!* Client must agree to terms: ***

I, the undersigned, understand that acupuncture and related therapies or methods may include but are not limited to, Shiatsu/Tui Na (Japanese & Chinese Massage), Reflexology, Sotai (Japanese form of Muscular Movement Therapy), Cupping, Electrical Needle Stimulation, Blood Letting, Yin Tui Na (A subtle, gentle, slow form of bodywork) are given for the purpose of benefiting my health and wellness (or on the patient named below, for which I am legally responsible).

I understand that diagnosis and treatment by the registered acupuncturist, Michaela Rezanoff, does not replace the diagnosis and treatment of a physician or dentist. In accordance with Section 8(1) of Alberta's Acupuncture Regulation, I have consulted with a physician or dentist for my condition prior to receiving acupuncture treatments or agree to seek consultation before any future acupuncture treatments.

I understand that decisions to alter or stop medications are at the discretion of a physician.

I understand risks and benefits of acupuncture as explained to me and consent to receive treatment by a registered acupuncturist, taking full responsibility for the outcome of the therapy. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

I attest that all information provided to my therapist is complete and true.

Client Signature

Practitioner Signature

Dated this day of



Month Day Year

***Important!* Client must agree to terms: ***

I understand that it is clinic policy to require a credit card on file for all acupuncture (reflexology, et al.) clients. If I do not wish to keep a card on file, I agree to prepay for any and all upcoming booked appointments.

I understand that there is a 50% late cancel (under 24hrs)/no show fee for any and all booked appointments, and that my credit card will be charged to cover the cost, and that missed fees are not covered by my insurance provider.

I understand that email, text and voicemail reminders are considered a courtesy provided to me, and that Glow Health & Vitality has no control over reminders that are not received, therefore I am still responsible for any and all fees incurred for any missed appointments in this situation.

Credit Card Authorization & Permission to Keep on File

I authorize Glow Health & Vitality, to keep my signature and current credit card information on file and to charge fees to my credit card account for services provided or for missed/late cancellations. Charges will be made within 48hrs at the fee according to posted services fee schedule. This agreement will be valid until expiration or written cancellation.

By paying via credit card, I acknowledge that the credit card information provided will be automatically kept on file via FOIP (Freedom of Information and Protection of Privacy) and HIPAA (Health Insurance Portability and Accountability Act) compliant encrypted software, and processed by secure and encrypted point of sale.

Credit Card Type	Credit Card Number	Exp. Date	CVC #
Visa			
MasterCard		mm/yy	
American Express			

If I choose not to have my credit card kept on file:

I agree that I must prepay for my appointments upon booking them and I am still responsible for any and all late cancel/no show fees. Charges for services rendered and/or missed fees will be taken from this prepaid amount on my file.

Client Signature

Dated this day of



Month Day Year