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 Povince/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?

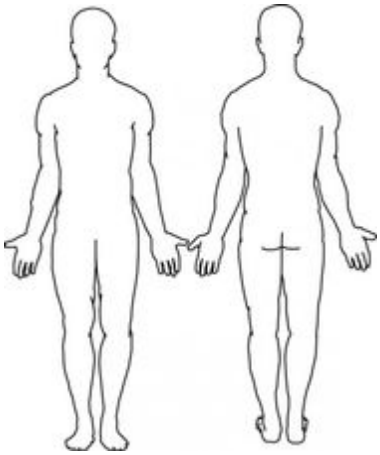
What makes it better or worse?

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

	0	1	2	3	4	5	
Poor	◯	◯	◯	◯	◯	◯	Excellent

If poor, please explain:

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?

- ◯ Heavy
- ◯ Moderate
- ◯ Rarely

Do you drink alcohol?

- ◯ Heavy
- ◯ Moderate
- ◯ Rarely

Do you smoke?

- ◯ Heavy
- ◯ Moderate
- ◯ Rarely

Any addictions?

Do you sleep well?

◯ Yes ◯ No

If not, please specify:

- ☐ Hard to fall asleep
- ☐ Nightmares/dreams
- ☐ Wake during night
- ☐ Night sweats
- ☐ Wake up too early
- ☐ Wake up for bathroom
- ☐ Restless
- ☐ 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

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

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

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 ovluation

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?

◯ Yes ◯ No

Please describe:

Vaginal infections?

◯ Yes ◯ No

Please describe:

Ovarian cysts?

◯Yes ◯No

Please describe:

Breast fibroids?

◯Yes ◯No

Please desribe:

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, Michaella 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

◯ Visa
◯ MasterCard
◯ American Express

Credit Card Number

Exp. Date

mm/yy

CVC #

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