Tailor Made Wellness Clinic

Acupuncture Intake Form

#200, 85 Cranford Way
Sherwood Park, AB T8H 0H9
Ph: 780-464-5220 Fax: 780-449-3302
www.tailormadewellness.com

Alberta Healthcare # (required for clinic paperwork purposes)	

Personal Information

Name	Date
Address	
City, Province	Postal Code
Phone.	OK to leave messages? ☐ Yes ☐ No
Alternate Phone:	OK to leave messages? ☐ Yes ☐ No
Birth Date:	Gender:
Marital Status:	
Email	
Occupation:	

Marketing Data Collection:

How did you hear about our clinic: ☐ Friend May we thank them? ☐ Yes ☐ No

☐ Phone book ☐ Sign ☐ Other

Emergency Contact Information

Emergency Contact:	
Phone:	Relationship
Medical Doctor:	Phone:
Name of Clinic:	
Are you currently under a physician's care? ☐ Yes ☐ No If Yes, for what?	

List all prescription medications your are currently taking (with dosage, if possible):

List all non-prescription medications or supplements your are currently taking:

Medical History	
Please identify your major health concerns:	
1.	How long?
2.	How long?
3.	How long?

Have you been given a diagnosis for these problems? If so, please provide the diagnosis:

What other treatments have you tried and what were the outcomes?

Family History:

	Mother	Father	Brother(s)	Sister(s)	Child(ren)	Other/Details
Overall Health (good,moderate,poor)	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	
Tuperculosis	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

Personal History:
Past and current medical diagnosis (given by certified medical professional), include date diagnosed:
List all allergies and sensitivities:
Do you have any contagious diseases (e.g. hepatitis, tuberculosis, flu) at this time? Please specify:
History of hospitalizations, surgeries, significant illnesses or injuries (what for, dates):
Are you scheduled for an upcoming surgery? if so, when and what for?
Do you have a pacemaker?
Do you have any medical implants? (e.g. plates or screws)
Lifestyle/Habits
Which of the following do you currently use? (Details/Dosage/Frequency)
☐ Caffeine
☐ Tobacco
☐ Alcohol
☐ Recreational Drugs
☐ Other (specify)

Please check all applicable Gastrointestinal symptoms/conditions:							
Nausea	☐	Diarrhea	☐	Hard Stools	☐	Vomiting	☐
Constipation	☐	Enteritis	☐	Acid Regurgitation	☐	Blood in stools	☐
Gastritis	☐	Gas	☐	Black stools	☐	Burning anus	☐
Hiccup	☐	Mucus in stools	☐	Itchy anus	☐	Bloating after meals	☐
Undigested food in stools	☐	Rectal pain	☐	Intestinal cramping	☐	Ulcerative colitis	☐
Hemorrhoids	☐	Stomach cramps	☐	IBS	☐	Laxative use	☐
Gurgling sounds	☐	Loose stools	☐	Bad breath	☐	Galls stones	☐
Peptic ulcers	☐	Diverticulosis	☐	Cholestasis	☐	Colon Cancer	☐
Hiatal hernia	☐						
Number of bowel movements per day:							
Please check all applicable Endocrine and Metabolic symptoms/conditions:							
Addison's Disease	☐	Diabetes Insipidus	☐	Hyperthyroidism	☐	Cushing's Syndrome	☐
Hyperglycemia	☐	Hypothyroidism	☐	Diabetes Mellitus(Type I)	☐	Obesity	☐
Hashimoto's thyroiditis	☐	Diabetes Mellitus(Type II)	☐	High Cholesterol	☐	Grave's Disease	☐
Please check all applicable Cardiovascular symptoms/conditions:							
High blood pressure	☐	Palpitations	☐	Orthostatic hypotension	☐	Low blood pressure	☐
Chest pain	☐	Fast heartbeat	☐	Fainting	☐	Heart attack	☐
Slow heartbeat	☐	Lightheaded	☐	Phlebitis	☐	Irregular heartbeat	☐
Deep vein thrombosis	☐	Peripheral Atherosclerotic	☐	Congestive Heart Failure	☐	Atrial fibrillation	☐
PVC	☐	Raynaud's Disease	☐	Buerger's Disease	☐	Angina pectoris	☐
Corpulmonale	☐	Coronary Artery Disease	☐				
Please check all applicable Respiratory symptoms/conditions:							
Feeling short of breath	☐	Green sputum	☐	Chronic cough	☐	Difficulty breathing lying down	☐
Clear Sputum	☐	Recurrent respiratory	☐	Productive cough	☐	Blood in sputum	☐
COPD	☐	Chest pain	☐	Sticky sputum	☐	Shortness of breath at rest	☐
Asthma	☐	Chronic Bronchitis	☐	Lung Cancer	☐		

Please check all applicable Genito-urinary symptoms/conditions:							
Painful urination	☐	Scant urination	☐	Clear urination	☐	Frequent urination	☐
Urination at night	☐	Retention of urine	☐	Copious urination	☐	Urinary incontinence	☐
Burning urination	☐	Frequent kidney infections	☐	Dark yellow urine	☐	Renal failure	☐
Frequent UTIs	☐	Light yellow urination	☐	Kidney stones	☐	Cloudy urination	☐
Please check all applicable Neuropsychological symptoms/conditions:							
Seizures	☐	Bell's palsy	☐	Addiction disorder	☐	Numbness/Tingling	☐
Depression	☐	Autism Spectrum	☐	Peripheral Neuropathy Anxiety	☐	Anxiety	☐
Anorexia Nervosa	☐	Trigeminal neuralgia	☐	Irritability	☐	Bulimia Nervosa	☐
Tics	☐	PTSD	☐	Chronic fatigue Syndrome	☐	Parkinson's	☐
Bi-polar	☐	Sleep apnea	☐	Multiple Sclerosis(MS)	☐	Abuse survivor	☐
Narcolepsy	☐	Dementia	☐	Vertigo	☐	Alzheimer's	☐
Easily Stressed	☐	Meniere's disease	☐	ALS	☐	Poor memory	☐
Headaches	☐						
Please check all applicable boxes relating to your sleep patterns:							
Insomnia	☐	Problems staying asleep	☐	Problems falling asleep	☐	Dream disturbed sleep	☐
Wake up tired	☐	Nightmares	☐				
Recurrently waking up around a certain time (please specify the time):							
Please check all applicable pertaining to your skin and hair:							
Rashes	☐	Psoriasis	☐	Alopecia/hair loss	☐	Hives	☐
Eczema	☐	Brittle hair	☐	Ulceration	☐	Oily skin	☐
Premature grey hair	☐	Dry skin	☐	Dandruff	☐	Rosacea	☐
Itchy skin	☐	Shingles	☐	Candidiasis Albicans	☐	Lipomas	☐
Fungal infections	☐	Basal Cell Carcinoma	☐				
Please check all applicable Musculoskeletal symptoms/conditions:							
Nerve pain	☐	Lower back pain	☐	Sciatica	☐	Shoulder pain	☐
Leg pain	☐	Spinal Stenosis	☐	Arm pain	☐	Knee pain	☐
Disc hernias	☐	Elbow pain	☐	Ankle pain	☐	Spondylolisthesis	☐

Hand pain	☐	Toe pain	☐	Fibromyalgia	☐	Finger pain	☐
Systemic Lupus Erythematosus	☐	Osteoarthritis	☐	Abdominal pain	☐	Gout	☐
Rheumatoid Arthritis	☐	Rib pain	☐	Tendonitis	☐	Osteoporosis	☐
Upper back pain	☐	Bone fractures	☐	Mid back pain	☐	Bursitis	☐
Joint replacement surgery	☐	Please specify:					
Please check all other applicable boxes:							
Glasses	☐	Grinding teeth	☐	Swollen glands	☐	Blurred vision	☐
Soft teeth	☐	Recurrent sore throat	☐	Eye strain	☐	Multiple cavities	☐
Sinus problems	☐	Red eyes	☐	TMJ	☐	Enlarged thyroid	☐
Itchy eyes	☐	Gum disease	☐	Earaches	☐	Spots in eyes	☐
Sore gums	☐	Poor hearing	☐	"Floaters" in vision	☐	Bleeding gums	☐
Ringing in ears	☐	Poor vision	☐	Sores on lips	☐	Nose bleeds	☐
Night blinded	☐	Sores on tongue	☐	Lump in throat sensation	☐	Glaucoma	☐
Canker	☐	Headaches	☐	Cataracts	☐	Dry mouth	☐
Migraines	☐	Eye strain	☐	Excessive saliva	☐	Concussions	☐

Anything else you think I should know?

Women's Health			
Is there any chance that you are currently pregnant?	☐ Yes ☐ No	If yes, how many weeks?	
Are you trying to conceive?	☐ Yes ☐ No		
Do you use birth control?	☐ Yes ☐ No	If so, what form of birth control?	
Number of pregnancies:		Number of miscarriages:	
Number of terminations:		Problems during pregnancy or delivery:	
Age you underwent menopause (if applicable):		Current menopausal symptoms (e.g. hot flashes, night sweats):	
Age of first menses:		Length of menstrual cycle:	

Length of menses:			
Any bleeding between cycles?	☐ Yes ☐ No	If YES, please identify frequency of bleeding between cycles:	

Please check all applicable:							
Regular menses	☐	Scant/light flow	☐	Pre-menstrual syndrome (PMS)	☐	Endometriosis	☐
Painful menses	☐	Amenorrhea	☐	Clots	☐	Heavy/excessive flow	☐
Other:							
History of sexually transmitted infections (please specify what and when):							
Date of last PAP smear:							
Abnormal findings (if any):							

Do you have any problems with:							
Decreased libido	☐	Breast Cancer	☐	Fibrocystic breast disease	☐	Infertility	☐
Breast masses	☐	Cervical Cancer	☐	Uterine Cancer	☐	Uterine Fibroids	☐
Ovarian Cancer	☐	PCOS	☐				
Do you have any other women's health concern's? Please specify:							

Men's Health:							
Do you have any problems with:							
Decreased libido	☐	Erectile dysfunction	☐	Difficulty urinating	☐	Infertility	☐
Ejaculation disorders	☐	Urinary incontinence	☐	Testicular pain	☐	Benign Prostatic Hyperplasia	☐
Prostate cancer	☐						
History of sexually transmitted infections (please specify what and when:							
Do you have any other men's health concerns? Please specify:							

CONCERNS PERTAINING TO TREATMENTS:
Please describe any concerns you have regarding your comfort and safety during an acupuncture treatment such as needle phobia, bleeding disorders, compromised skin, etc.: