Intake Form

Please fill out the following double sided intake form and waiver as detailed as possible it will help to ensure safe and appropriate treatment. The following information is strictly confidential. Please note: Toronto Acupuncture Center enforces a *24 hour cancellation policy*. Full treatment price will be charged without exception either by extracting a treatment from a pre-paid package or by an additional charge.
Out of respect for clients being treated after you, treatment time will not be extended beyond your scheduled time. Your punctuality is appreciated.

Name:____ Today's Date________________ Date of Birth:__________

Address:______________________________ City:__________ Postal Code:__________-__________

Occupation:___________Phone #'s- Cell:(____)____________ Home:(____)____________ E-mail: ________________

Describe Condition(s) you would like focused On:
____
____
____

Current Medical conditions:_____________________
____
Previous Medical conditions-____________________________
____
Trauma/Accidents (please specify dates)_________________
____
Surgery: (Please specify dates)______________________
____
Medications/Vitamins/Herbs___________________________

Please √ Current or Previous Conditions

General Health:

Depression ☐ Irritability ☐ Anxiety ☐ Diagnosed Mental Illness ☐

HIV/AIDS ☐ Blood Thinning Meds ☐ Fatigue ☐ Epilepsy ☐

Hepatitis ☐ Diabetes ☐ Bleeding Disorders ☐ Cancer ☐ Night sweats ☐

Alcohol ☐ Addiction Issues ☐ Sleep- Trouble falling asleep ☐ Trouble staying asleep ☐ trouble waking in morning ☐

Other/Details:____

Respiratory:

Smoker ☐ Pneumonia ☐ Asthma ☐ Phlegm in Lungs ☐ Shortness of Breath☐ Emphysema ☐

Environmental Allergies ☐ Cough ☐ Bronchitis ☐

Other/Details: ____

Musculoskeletal:

Shoulder Pain ☐ Back Pain ☐ Pins & Needles ☐ Osteoporosis ☐ Repetitive strain/overuse☐

Shoulder Tension ☐ Back Tension ☐ Numbness ☐ Where:__________ Where:_______________

Neck Pain ☐ ↑ Where on your Back? Ligament/ Tendon Injury ☐ Swelling/Edema ☐ Arthritis ☐

Upper back ☐ Where:_________ Which areas:______________

Neck Tension ☐ Mid back ☐ Herniated Disk ☐ _________________ __________________

Hip problems ☐ Low back ☐ Injuries/Fractures ☐ _________________ ___________________

Knee/ foot /ankle problems ☐ Elbow/wrist/hand problems ☐

Other/Details:____

Cardiovascular:

High Blood Pressure ☐ Dizziness ☐ Stroke ☐ Cold Areas of Body:

Low Blood Pressure ☐ Blood Clots ☐ Varicose Veins ☐ ________________________________

Heart Attack ☐ Irregular Heartbeat ☐ Pace Maker ☐ Other:_______________________________

Fainting ☐ Palpitations ☐ Chest Pain/Discomfort ☐ ________________________________

Hepatitis ☐ ________________________________

Reproduction/Genito-Urinary:

How long does you Period last?________ How often does you Period come?________ Fibroids/Cystes/Endometiosis ☐ PMS Symptoms ☐

Irregular Periods ☐ Painful Periods ☐

Flow: Heavy ☐ Moderate: ☐ Light: ☐ Menopause ☐ Hormone Issues (replacement, Diseases etc) ☐

Erectile Dysfunction ☐ Ejaculatory Dysfunction ☐ Prostate Problems ☐ Urination Problems ☐

Kidney Stones ☐

Other/ Details:____

Digestion:

Diarrhea ☐ Gas ☐ Acid Reflux ☐ Eating Disorder ☐ Appetite: excessive☐ lack of ☐

Nausea/ Vomiting ☐ Belching ☐ Gallbladder/Liver probs.☐ Bloating ☐ Constipation ☐

Tired after meals ☐ Bad Breath ☐ Dry Mouth at Night ☐

Other/Details:____

Skin:

Rashes ☐ Eczema ☐ Acne ☐ Itchy ☐ Dry Skin ☐ Hives☐ Bleed/Bruise Easily☐ Herpes ☐ Hair Loss ☐

Other/Details:____

Head, Eyes Nose and Throat:

Thyroid condition ☐ Eye Problems ☐ Sore throat☐ Concussion ☐ Migraines ☐ Headaches ☐ where & when___________

Enlarged Glands ☐ Facial Pain ☐ Jaw tension ☐ Sinus Congestion ☐ Hearing Loss ☐ Ear Ringing ☐ Ear aches☐

Other/Details:____