



# PATIENT INTAKE FORM

**OFFICE USE ONLY**

Case # \_\_\_\_\_

Date \_\_\_\_\_

Patient Contact Info

Name	Preferred Phone #	M or F	Occupation
Address	City	Postal Code	Family doctor
Email	DOB (D/M/Y)	Age	Last visit to doctor



Medical History

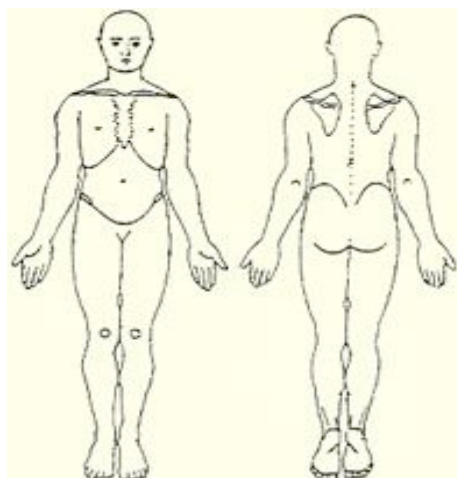
Check all that apply:

<input type="checkbox"/> Abdominal problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Addictions	<input type="checkbox"/> Back pain	<input type="checkbox"/> Bed Wedding	<input type="checkbox"/> Bone Spurs
<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Breast pain	<input type="checkbox"/> Breast Implants	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bunions	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Buttock pain	<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Colic	<input type="checkbox"/> Constipation	<input type="checkbox"/> Depression
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ear problems	<input type="checkbox"/> Oedema
<input type="checkbox"/> Fatigue (chronic)	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Fracture (old/new)	<input type="checkbox"/> Hernia
<input type="checkbox"/> Hamstring problems	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Gallbladder problems	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Hormone issues	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Jaw & TMJ problems	<input type="checkbox"/> Infertility	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Liver problems
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Migraines	<input type="checkbox"/> Knee problems	<input type="checkbox"/> Numbness
<input type="checkbox"/> Orthodontia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Targeted Pain	<input type="checkbox"/> Pelvic problems
<input type="checkbox"/> Plantar Fasciitis/Feet	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Rib problems
<input type="checkbox"/> Sacral problems	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Shin splints
<input type="checkbox"/> Shoulder problems	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Tennis Elbow	<input type="checkbox"/> Tinnitus

Please describe (\*):

Energy level:	High   Medium   Low	____ hrs of sleep/day	____ bowel movements/day
Stress level:	High   Medium   Low	Reproductive:	Pregnant   Yes   No
Exercise level:	High   Medium   Low	Menses: _____ days/cycle	Spotting?   YES   or   NO
Mechanical obstructions/Implants/Devices:		PMS symptoms: _____	
Contraindications:	Cancer   Diabetic AIDS   H/L Blood Haemorrhagic TB   Other*	Overlap of certain medication:	Diabetic High BP Low BP

Previous hospitalizations:	Medications:
Allergies:	Vitamins/Supplements:
Overview of Lifestyle/Dietary Restrictions:	
List all accidents, injuries, surgeries, transplants and falls you can remember(incl. emotional traumas):	
Primary Concerns/Pains/Discomforts:	



Please indicate any areas of pain or discomfort:

X for sharp, sever pains

Circles for dull aches

Lines may indicate tension



Patient Release

This is to acknowledge that:

1. I have been informed about the Acupuncture/Reiki/Bowen treatment being offered and that I fully understand and accept that this treatment is being done by a practitioner who is not a medical doctor.
2. I understand that therapy is not meant to treat or cure any specific disease and this treatment is not for diagnosing, prescribing or to replace my family doctor.
3. I understand that Acupuncture, Reiki and Bowenwork are hands on therapies and I give my permission for the therapist to touch my body.
4. I agree to this information being stored and used as part of the specialists' records and consent to the treatment offered.
5. I do not wish to have this personal information given to any other person or business.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

