



5950 Rochdale Blvd.
Regina, SK S4X 4J7

Ph: (306) 545-3700
Fax: (306) 545-8105
E-mail: rehab@sasktel.net

Acupuncture Intake Form

Patient Name: _____

Date: _____ Date of Birth: ___/___/___

Major Complaints:

1) _____ 2) _____
3) _____ 4) _____

Details regarding Major Complaint:

Where is the problem located? _____

When did it start? _____

Have you had this pain before? When? _____

How did it start? _____

Is it getting worse? ___ coming and going ___ getting better _____

How often does it bother you? _____

Is there a pattern- Time of day _____ Time of year/season _____

What makes it better? Heat ___ Cold ___ Pressure ___ Other _____

What makes it worse? Heat ___ Cold ___ Pressure ___ Other _____

Describe the pain: Dull/Aches ___ Shooting ___ Other (pin prick, tight, squeezing, band sensation, expanding...) _____

Does the pain radiate anywhere? _____

Severity of pain out of 10 (10= worst pain) _____

Skin:

Do you have any skin conditions? Yes ___ No ___

Do you have: Dry skin ___ Itchy ___ Moist/clammy ___ Burning ___
changing moles or lumps ___ cysts ___ boils ___ frequent skin rashes ___

Acne ___ hair loss/thinning ___ dry scalp ___ puffy skin ___ wrinkles ___

easy to bruise ___ hives ___ scars (from what?) _____

Other _____

Head:

Do you get headaches? Yes ___ No ___ how often? _____

What area of the head? Temples ___ behind eyes ___ at top of head ___

Side(s) ___ back ___ one sided ___ worse side _____

Do you have: memory loss? ___ loss of balance ___ dizziness _____

Eyes:

How is your vision? _____ Any changes to your vision? _____

Do you have? Blurred vision _____ Redness _____ Night blindness _____ dry eyes _____ decreased vision _____ floaters: _____ both eyes _____ Lots _____ few _____

Ears:

How is your hearing? _____ any recent changes to your hearing _____

Have you experienced deafness in either or both ears? _____

Was the onset gradual _____ or sudden _____

Have you experienced ringing of the ears? _____ if so, check the following:

High pitched _____ worse with pressure _____ low pitched _____ gradual onset _____ better with pressure _____

Have you had ear aches? _____ ear discharges _____ infections _____

Nose:

Nose bleeds frequently _____ sinus trouble _____ frequent colds _____ other _____

Throat:

Sore throat (describe) _____ hoarse _____ difficulty swallowing _____ teeth or gum problems _____ swollen tongue _____

Respiration and Voice:

Are you a loud talker _____ soft talker _____

Do you need to constantly clear your throat? _____

Do you get frequent coughs? If so, which kind: feeble(weak) _____ asthma _____

Dry cough with phlegm production that is too sticky to cough up _____

Dry cough with small amounts of: phlegm _____ blood tinged _____

Cough with lots of phlegm _____ persistent cough _____ other _____

Consistency of phlegm _____ colour _____

Breathing: difficulty _____ wheezing _____ mucus rattles when breathing _____

troubles breathing at night _____ do you need 2+ pillows when sleeping? _____

Shortness of breath? Yes _____ no _____ when? _____

If so, is it: worse on exertion? _____ worse with a cough/asthma? _____

Associated with: heart palpitations _____ emotional problems _____ loose stools _____ low back pain/arthritis _____

Chest: pain _____ pressure _____ palpitations _____ heart disease _____

Other _____ Blood Pressure: high _____ low _____

Digestion:

how is your digestion? _____

How many bowel movements do you have daily? _____

Stool consistency: hard _____ soft _____ loose _____ diarrhea _____ undigested food _____ blood _____ mucus _____

Do your stools: sink ___ float ___
Colour: honey brown ___ grey ___ black ___ green ___ red ___ bloody ___
streaked with red ___ multiple colours ___ other _____
Check if appropriate:
Loose stool: watery with mucus ___ undigested food and cold
symptoms ___ undigested food, bloating and gas ___ early morning
diarrhea (around 5am) ___ frequent with pain on defecation ___
Constipation: dry and malodorous ___ dry with fatigue ___ dry with cold
symptoms ___
Alternating loose stools then hard ___ dry then loose ___ pain on
defecation and anal burning ___ heavy, bearing down sensation in the
anus ___ mucous stool ___ hemorrhoids ___ malodorous stool ___
bloating ___ red and swollen gums ___ indigestion/ heart burn ___
Belching ___ sour regurgitation _____

Urine:
Colour: light ___ dark ___ other _____
Excess urination ___ urination at night ___ infrequent or unable to
urinate ___ blood in urine ___ frequent bladder infections ___ water
retention ___ where? _____ other _____
Does your water intake equal your output? _____ any incontinence? _____

Thirst:
How much water do you drink/day? ___ litres
Excess thirst ___ No thirst ___ Do you: chug ___ or sip ___
Temperature preference of beverages _____

Appetite:
Excess appetite ___ Poor appetite ___ Appetite keeps changing ___
Feel tired or weak if meal missed ___ What are your food cravings?

Female:
Age started menses ___ age stopped menses ___ vaginal discharge:
yellow ___ clear ___ white ___ yellow ___ thick ___ itching ___ odor
resembling _____
Menstrual pain? ___ low back pain ___ irregular menses ___ no menses
___ clots with menses ___ size _____ colour: purple-red ___ black-red
___ bright red ___ brown flow at beginning of menses ___ number of
pads or tampons used per day _____ heavy ___ light bleeding _____
Water retention ___ where? _____ breast tenderness ___ moodiness _____
Low sex drive ___ high ___ hot flashes ___ when? _____
food cravings _____ Pregnant ___ Last monthly period
_____ Last PAP test ___ / ___ / ___ Form of birth control _____

of pregnancies ___ # of deliveries _____ # of miscarriages _____
of abortions _____ # of cesareans _____ any operations: cervix _____
uterus _____ ovaries _____ any cysts _____ fibroids _____ endometriosis _____

Male:

Low sex drive ___ lack of sex drive ___ impotence ___ ejaculation causing
pain ___ penile discharge? _____ colour _____ pain on urination _____
Burning _____ premature ejaculation _____ prostate trouble ___ other _____
Do you get a daily morning erection? Yes ___ no ___ is it difficult to
achieve an erection? Yes ___ no _____

Reproductive:

Libido- high ___ average ___ low ___ Has it increased ___ decreased _____
Have you experienced fertility issues? ___ if so, which partner and what
has been tested? _____

Musculoskeletal:

Pain in: neck ___ shoulder ___ between shoulders ___ arms ___ hands ___
fingers ___ hip ___ knee ___ big toe ___ upper back ___ mid back ___ low
back ___ sore bones ___ loss of grip ___ swollen knees/elbows ___ leg
cramps at night ___ leg weakness ___ weak ankles ___ stiff all over ___
tingling? ___ where? ___ muscle spasm ___ cramps ___ loss of feeling
___ where? ___ painful joints ___ bursitis ___ other _____

Neurological :

Nervous ___ depressed ___ easily angered ___ easily irritated ___ frequent
crying ___ worry/anxiety ___ mood swings ___ memory confusion ___ poor
concentration ___ suicidal ___ tremors ___ numbness /tingling ___
coordination problems ___ muscle weakness ___ other _____

Temperature and Circulation:

General temperature: Hot ___ cold ___ area: _____
Neutral ___ do you sleep with: feet out ___ light covers ___ no covers _____
normal ___ lots of covers ___ do you need to wear many layers to keep
warm ___ do you like: warm drinks ___ spicy foods ___ are you cooler
than others ___ do you like cold, raw foods ___ do you get a warm sensation
around your chest, palms and soles of your feet all at the same time _____
do you bleed easily _____ do you have cold hands/feet _____

Sweating:

Rarely sweat ___ excess sweating ___ night sweat ___ If you have night sweats do you wake in a full sweat, not aware that you were sweating, then it stops when awake or moving ___ or do you sweat all night, you are aware of it, and it is due to the temperature of the room, and it does not change with moving ___ Do you sweat spontaneously (not on exertion or with movement) ___ do you find you are not sweating when others around you are? _____

Sleep:

Quality of sleep- poor ___ good ___ excellent ___
Do you wake feeling refreshed? ___ # of hours of sleep/night ___ are you a morning person ___ night person ___
Is it hard to stay awake after eating ___ do you nap ___ Time ___ how often do you need to nap? ___
Do you have trouble falling asleep: ___ with dizziness and /or heart palpitations ___ with restlessness and dream disruption ___
Following a big/late meal ___ or with irritability ___
Dreams: can't remember ___ don't have them ___ excess dreaming ___ nightmares ___ day dreaming ___

Energy:

Please rank your average daily energy out of 10 (10 = good) _____

Mood:

Please describe your mood _____
The dominant emotion that you feel is: fear ___ anger ___ worry ___ jealousy ___ sadness ___ grief ___ depression ___ joy ___ other _____

Stress:

None ___ moderate ___ severe ___ cause _____
How high is your stress out of 10 _____

Nutrition:

Do you: skip breakfast ___ eat a snack ___ hearty breakfast ___ # meals per day ___ biggest meal of the day is _____ do you eat if you are worried or rushed ___ # alcoholic drinks/week ___ # cigarettes/day ___ # of smoking years ___ eat the same food mostly ___ eat when not hungry ___ snack at night ___ hydrate without using water ___ always add salt to meals ___ eat until full ___ eat many small meals throughout the day ___ forget to eat ___ I generally: make my own food ___ eat out _____