Dr. Corey
ND RMT RAc

Acupuncture Intake Form

General Information

Name: _____ Date: _____ DOB: _____ F☐ M☐
Address: _____ City: _____ Prov.: ____
Postal Code: _____ Home #: _____Bus. #: _____
Cell #: _____ E-mail _____
Where may we contact you? All ____ Home ____ Bus ____ Cell ____ Email _____
Family Doctor: _____ Phone number: _____
Other Specialist: _____ Physiotherapist: _____
Massage Therapist: _____ Chiropractor: _____
Naturopath: _____ Other: _____

List Major Concern in order of importance

Concern	Cause	Date Started	Type of Rehab/Care

Symptoms List your symptoms associated to your concern, including level of pain on a scale of 1-10 and any numbness.

Symptom	Pain/Numb

Other Symptoms Only mark if you experienced in the past or present.

☐fatigue
☐poor endurance
☐blackouts
☐hair loss
☐confusion
☐nervousness
☐depression
☐insomnia
☐nightmares
☐muscle tension
☐muscle cramps
☐neck pains
☐fever
☐dizziness
☐ringing in ears
☐earaches
☐blurry vision
☐eyestrain
☐nasal congestion
☐sinus pressure
☐nosebleeds
☐hayfever
☐swollen glands
☐mucous problems
☐gas
☐abdominal pains
☐heart palpitations
☐chest pains
☐breast cysts/ pain
☐nausea/ vomiting
☐difficult digestion
☐fatty foods aggravate
☐constipation
☐diarrhea
☐thin stool
☐straining

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- ☐ back pains
- ☐ bone/joint swelling
- ☐ leg/ arm swelling
- ☐ numbness/ tingling
- ☐ cold hands/ feet
- ☐ itching
- ☐ rashes
- ☐ acne
- ☐ eczema
- ☐ psoriasis
- ☐ warts
- ☐ sores in mouth
- ☐ coated tongue
- ☐ bad breath
- ☐ sore throat
- ☐ cough
- ☐ dental problems
- ☐ difficult breathing
- ☐ shortness of breath
- ☐ coughing blood
- ☐ change in mole
- ☐ hemorrhoids
- ☐ bloody/ black stool
- ☐ night urination
- ☐ urinary problems
- ☐ bladder infection
- ☐ bedwetting
- ☐ blood in urine
- ☐ infertility
- ☐ sexual difficulties
- ☐ menstrual irregularity

List Medications, Prescriptions and Over the Counter — Used to treat . . .

_____ _____
_____ _____
_____ _____

List Herbal Supplements, Vitamins & Minerals

_____ _____
_____ _____
_____ _____

List any Surgery and the — Year

_____ _____
_____ _____
_____ _____

List and Injury or Accident and the — Year

_____ _____
_____ _____
_____ _____

List and major illnesses and or hospitalization and the — Year

_____ _____
_____ _____
_____ _____

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Please write the year or approximate age that you have incurred any of the following conditions:

- ☐ anemia
- ☐ arthritis
- ☐ bronchitis
- ☐ cancer
- ☐ chicken pox
- ☐ colitis
- ☐ crohn's
- ☐ diabetes
- ☐ diphtheria
- ☐ hives
- ☐ drug reaction
- ☐ eczema
- ☐ emphysema
- ☐ epilepsy
- ☐ gallstones
- ☐ heart attack
- ☐ heart disease
- ☐ HB pressure
- ☐ LB pressure
- ☐ HIV/AIDS
- ☐ hypoglycemia
- ☐ jaundice
- ☐ kidney infection
- ☐ kidney stones
- ☐ hepatitis
- ☐ measles
- ☐ mumps
- ☐ mental problems
- ☐ migraines
- ☐ obesity
- ☐ parasites
- ☐ pneumonia
- ☐ psoriasis
- ☐ rheumatic fever
- ☐ skin boils
- ☐ syphilis
- ☐ herpes
- ☐ tuberculosis
- ☐ asthma
- ☐ hooping cough

Any other medical diagnosis you have, past or present: _____

_____

All the information given today is complete to your knowledge and accurately reflects your past and present health.

Client Signature _____ Date _____