



NORTHVIEW ACUPUNCTURE CLINIC

Please complete this form and bring it to your first appointment.

INTAKE FORM

NAME: _____

ADDRESS: _____

CITY: _____

POSTAL CODE: _____

DATE OF BIRTH: D _____ M _____ Y _____

OCCUPATION: _____

EMERGENCY CONTACT: _____

PHONE: _____

TEL: HOME #: _____
WORK #: _____
OTHER #: _____

EMAIL: _____

FAMILY DOCTOR: _____

PHONE: _____

Where did you hear about us? _____

Are you participating in any other therapies? If yes, please indicate;

Physiotherapy Chiropractic Massage Other _____

How often: _____

Please check if applicable;

Vegetarian

Smoker

Pregnant

Drink Alcohol

Allergies; if yes, please indicate; _____

Asthma

Cancer; Type; _____

Diabetes; Type; _____

Seizures

Insomnia

HIV

Hepatitis

Blood Thinners

STD

Pacemaker

High Blood Pressure

Low Blood Pressure

Surgery/major trauma/other diseases not listed above: _____

Are you taking any medication?

If yes, please indicate what type and reason: _____

Family Medical History: _____

Have you every had acupuncture before?

If yes, please indicate when and reason why: _____

*PHN # _____ (MSP patients only)