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

☐ Insommnia ☐ 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: _____

_____

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