



# NORTHVIEW ACUPUNCTURE CLINIC

## 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; \_\_\_\_\_

- |                                   |  |  |   |
|-----------------------------------|--|--|---|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Cancer; Type; _____ | <input type="checkbox"/> Diabetes; Type; _____ | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Blood Thinners     |
| <input type="checkbox"/> STD      | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> 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)