ACUPUNCTURE INTAKE FORM

Sawaddee Massage & Wellness
2425 Maple Rd NW Edmonton AB T6T 0Y3 / Phone: 780-708-2115
reception@sawaddeemassage.net / management@sawaddeemassage.net

Patient Name		**Date**	
Address/Postal Code		**Age**	
Telephone		**Birthdate**	
Email		**Occupation**	
Emergency Contact		**Height**	
Relationship		**Weight**	
Emergency Contact #		**Sex at birth**	
Family Doctor		**Doctor Phone #**	

Main Complaint(s) in order of importance: **When did it start:** **Past treatment:**

1 _____ _____ _____
2 _____ _____ _____
3 _____ _____ _____

Do you have a contagious disease? ❑ No ❑ Yes - please specify _____
Do you have a pacemaker? ❑ No ❑ Yes Do you have metals/pins in your body? ❑ No ❑ Yes Are you pregnant? ❑ No ❑ Yes
Do you have allergies? ❑ No ❑ Yes - please specify _____

Patient History & Lifestyle (please check all that apply & use the comments section to explain further)

Family Medical History
- ❑Allergy
- ❑Cancer
- ❑Seizure
- ❑Diabetes
- ❑Alcoholism
- ❑Asthma
- ❑Hypertension/High Blood Pressure
- ❑Stroke
- ❑Heart Disease
- ❑Kidney Disease
- ❑Mental Illness
- ❑Other (specify) _____

Comments: _____

Past Medical History
- ❑Allergy
- ❑Cancer
- ❑Seizure
- ❑Diabetes
- ❑Alcoholism
- ❑Asthma
- ❑Hypertension
- ❑Hypotension
- ❑Stroke
- ❑Heart Disease
- ❑Bleeding Disorders
- ❑Hyperthyroid
- ❑Hypothyroid
- ❑Mental Illness
- ❑STD
- ❑Liver Disease
- ❑Accidents/Trauma
- ❑Arthritis
- ❑Birth Trauma
- ❑Childhood Illness
- ❑Other (specify) _____

Hospitalizations and surgeries? (details)

Comments: _____

Current Lifestyle
- ❑Smoking
- ❑Alcohol
- ❑Street Drugs
- ❑Caffeine
- ❑Medications _____
- ❑Herbs/Homeopathic _____
- ❑Vitamins _____
- ❑Diet _____
- ❑Water - Cups/day _____
- ❑Exercise _____
- ❑Occupational Stress
- ❑Major Trauma _____
- ❑Other (specify) _____

Comments: _____

Conditions

Temperature
Do you experience any chills/fever?
❑Yes ❑ No ❑ Alternating
❑Day ❑ Night
❑Spontaneously
Are you typically:
❑Hot ❑ Cold ❑ Comfortable
Hands/Feet:
❑Hot ❑ Cold ❑ Comfortable
❑Heat in palms, soles & chest
❑Other (specify) _____
Comments: _____

Perspiration
Do you sweat?
❑Yes ❑ No
❑Day ❑ Night
❑With exertion ❑Without exertion
❑Spontaneously
❑Odour
❑Discolour clothes
❑Other (specify) _____

Comments: _____

Sleep
Do you sleep well?
❑Yes ❑ No
Number of hours per night? _____
❑Trouble falling asleep
❑Trouble staying asleep
❑Recurrent dreams
❑Trouble getting out of bed
❑Tired during the day, worst time _____
❑Energy level _____
❑Other (specify) _____
Comments: _____

Hyacinth Urrutia, Dr.Ac.

ACUPUNCTURE INTAKE FORM

Pain (Muskuloskeletal)
Do you have pain? ❑ Yes ❑ No
❑Fixed ❑ Radiates
❑Constant ❑ Intermittent
❑Relieved by _____
_____
❑Aggravated by _____
_____
❑Worse in ❑ AM ❑ PM ❑ Same
Type of Pain: (pls. encircle)
❑ Dull /achy /sharp /numb /pins & needles /stabbing /spasm
❑ Location _____
Comments: _____
_____

Neurological
❑Seizures/Epilepsy
❑Headaches
❑Vertigo/Dizziness (pls. encircle)
❑Weakness/Paralysis (pls. encircle)
❑Numbness/Tingling on face or limbs
❑Loss of balance
❑Lack of coordination
❑Concussion
❑Other (specify) _____
Comments: _____
_____
_____
_____

Head, Eye, Ear, Nose & Throat
❑Poor Hearing
❑Ringing in ears
❑Earaches
❑Poor Vision
❑Eye pain/Strain
❑Blurry Vision
❑Floaters/Spots
❑Glasses/Contacts
❑Tearing/Dryness
❑Sore throat frequent
❑Cataracts
❑Glaucoma
❑Jaw/Facial pain
❑Teeth/Gum issues
❑Sinus problems
❑Nose bleeds
❑Other (specify) _____
Comments: _____
_____
_____
_____
_____

Respiratory
❑Frequent colds/flu
❑Cough
❑Sputum/Phlegm - Colour _____
❑Shortness of Breath
❑Hemoptysis/Coughing up blood
❑Asthma
❑Pneumonia
❑Chest oppression/tightness
❑Other (specify) _____
Comments: _____
_____
_____
_____

Cardiovascular
❑Irregular heart beat/murmur
❑Palpitations
❑Chest pain
❑Cold hands/feet
❑Hypertension/ Hypotension (encircle)
❑Fainting/Light headed
❑Swelling hands/feet
❑Blood Pressure ____/____ Date _____
❑Bruise easily
❑Other (specify) _____
Comments: _____
_____
_____

Appetite
❑Excess ❑ Good ❑ Poor
❑Recent Changes _____
❑Food cravings _____
❑Unusual Tastes (bitter, metallic, etc.)
❑Weight gain/loss
❑Always Thirsty ❑ Never Thirsty
❑ Thirsty w/ no desire to drink
❑ Prefers little sips throughout the day
❑Drinks hot/cold/room temp. (encircle)
❑Feeling of fullness after meals
❑Other (specify) _____
Comments: _____
_____

Gastrointestinal
Frequency of bowel movement _____
❑Last bowel movement _____
❑Nausea/Vomiting (pls. encircle)
❑Heartburn/Indigestion/Ulcer (encircle)
❑Abdominal pain/cramps
❑Gas/bloating
❑Constipation/Diarrhea (pls. encircle)
❑Blood in stools
❑Hemorrhoids/rectal pain
❑Bowel incontinence
❑Unusual color/odor of stools
❑Undigested food/mucous in stools
❑Liver/Gallbladder issues _____
❑Other (specify) _____
Comments: _____
_____
_____

Genitourinary
Frequency of urination _____
Color of urine _____
❑Scanty ❑ Normal ❑Profuse
❑Painful urination
❑Frequency/urgency
❑Frequent UTI
❑Blood in urine
❑Frequent urination at night
❑Urinary incontinence
❑Kidney disease
❑Kidney stones
❑Impotence
❑Other (specify) _____
Comments: _____
_____
_____
_____

Female Reproductive
Age of first menses _____
Days of Flow & Cycle Length _____
Age of menopause _____
Are you pregnant?
❑Yes ❑ No
Pregnancy _____
Miscarriage____
Abortion _____
❑Birth control
❑Vaginal discharge
❑Odour/ Colour
_____
❑STD
❑Other (specify)
_____
Menstrual colour
_____
❑Menstrual clots
❑Painful menses
❑Heavy flow
❑Irregular menses
❑PMS
❑Breast lumps
❑Menopause Symptoms
Libido: ❑ Excess ❑ Normal ❑Low
Comments: _____
_____

Skin and Hair
❑Rashes/hives
❑Eczema/psoriasis
❑Itchiness
❑Ulcerations
❑Recent moles/ changes
❑Pimples
❑Dandruff
❑Changes in hair/skin texture
❑Other (specify) _____
Comments: _____
_____
_____

Psychosocial
❑Temper/anger problems
❑Depression/anxiety/stress (pls. encircle)
❑Emotional disorder
❑Insomnia
❑Poor Memory
❑Other (specify) _____
Comments: _____
_____
_____

Male Reproductive
❑Testicular Pain/Swelling
❑Impotence/Erectile Dysfunction
❑Prostate Problems
❑Sexually Transmitted Disease
Libido: ❑ Excess ❑ Normal ❑Low
Other (specify) _____
_____
Comments: _____
_____

CONSENT AND RELEASE FORM

I, the undersigned, do hereby declare that the information I provided on this Intake Form is complete and correct to the best of my knowledge. I understand that it is my responsibility to update any changes to my medical history. I authorize **Hyacinth Urrutia, Dr.Ac.** to perform any of the following as deemed appropriate for my condition:

- **Acupuncture:** insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the body.
- **Electroacupuncture:** using small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** applying heat generated by an infrared lamp over a specific area of the body.
- **Moxa:** indirect or direct burning of an herbal compound on acupuncture points using stick or cone moxa.
- **Cupping:** cups made of glass or other materials are placed on the skin with a vacuum created by heat or suction device.
- **Gua Sha:** involves repeated pressured strokes over the skin with a smooth edged tool.
- **Tui Na:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** herbal formulas applied topically to the skin.
- **Nutritional Advice:** includes diet and herbal recommendations.
- **Laser:** focused light to stimulate acupuncture points.

I understand the potential benefits and risks of these procedures include:

- **Potential Benefits** (including but not limited to): drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement, or elimination of the presenting problem.
- **Potential Risks** (although rare, minimal, and short term, include but are not limited to): temporary pain or discomfort, bruising, bleeding, fainting, burns, possible temporary aggravation of symptoms existing prior to the acupuncture treatment.
- ***Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to treatment. acknowledge***

I voluntarily consent to the above procedures, acknowledging that no guarantees have been given to me regarding cure or improvement of my condition. In order for the above named practitioner to perform these procedures, I release her from any liability that may occur in connection with my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time. I intend this consent to cover the entire course of care for my present condition and for any future conditions for which I seek care for.

Cancellation Policy:

I understand that I am required to give a **24-hour notice** to cancel/change my appointment so that another patient in need of treatment can be accommodated. If I neglect to give 24 hours notice (without a valid reason), **I will be charged for the full amount of the treatment.**

_____ _____

Signature of Patient (or parent/guardian if under 18) **Date Signed**

_____

Print Patient's Name

How did you hear about Hyacinth Urrutia, Dr.Ac.?

❑ Internet search ❑ Referral from _____ ❑ Other (specify) _____

I agree that Hyacinth Urrutia, Dr.Ac. may send me communications by email. ❑ Yes ❑ No

Patient / Guardian Signature: _____