**Koru Natural Health Centre: Acupuncture Intake Form**

Today's date: _____ Name: _____

Address: _____

Postal Code: _____ Date of Birth: _____ Occupation: _____

Telephone: (h) _____ (w) _____ Email: _____

Emergency contact: _____Emergency Telephone: _____

Doctor's name: _____ Were you referred by someone? _____

What do you hope to gain from acupuncture treatment? _____

**Medical History:**

Existing health conditions (if any): _____
_____
_____
_____

Surgeries: _____
Physical trauma: (i.e. car accident, injuries): _____
Allergies: _____
Aids/HIV: _____ Hepatitis: _____ High Blood Pressure: _____
Bleeding Disorders: _____

**Family History:**

Have you or any immediate blood-related family member experienced the following:

| | | | |
|---|---|---|---|
| Heart attack: | me: □ relative □ | High Blood pressure: | me: □ relative □ |
| Heart disease: | me: □ relative □ | Mental/emotional disorders: | me: □ relative □ |
| Stroke: | me: □ relative □ | Asthma: | me: □ relative □ |
| Diabetes: | me: □ relative □ | Emphysema: | me: □ relative □ |
| Cancer: | me: □ relative □ | Kidney Disease: | me: □ relative □ |
| Seizures: | me: □ relative □ | Bleeding/Blood disorders: | me: □ relative □ |
| TB: | me: □ relative □ | Autoimmune disorders: | me: □ relative □ |
| Skin disease: | me: □ relative □ | Osteoporosis: | me: □ relative □ |
| Arthritis: | me: □ relative □ | Thyroid condition: | me: □ relative □ |

Please list any medications or supplements that you are currently taking:

_____
_____

Coffee: _____ (cups per day) Cigarettes _____ (per day)

Are you currently receiving any of the following treatments?

| | | | | | |
|---|---|---|---|---|---|
| Acupuncture | □ | Naturopathy | □ | Physiotherapy | □ |
| Chiropractic | □ | Massage therapy | □ | Other (list) | □ |