131 Union Street East.
Suite #103
Waterloo, ON
N2J 1C4

The Natural Way
HEALTH CLINIC
where healing begins

(T) 519-772-2116
(F) 866-731-5603
www.thenaturalwayclinic.com

ACUPUNCTURE SPECIFIC INTAKE FORM

A naturopathic approach to medicine is holistic and seeks to understand all factors that may be affecting your health. Please answer the following questions to the best of your ability.

Name: _____ Date: _____
Date of Birth: _____ (m/d/y) Age: _____ Sex: Male / Female/Other
Mailing Address: _____
City: _____ Postal Code: _____
Email: _____

Telephone:		May we leave a message?
Home/Eve:	(____) _____	YES / NO
Work/Day:	(____) _____	YES / NO
Cell:	(____) _____	YES / NO

What is the best way to contact you? HOME / WORK / CELL

☐ **I give my consent to include my e-mail address on the clinic newsletter mailing list**

How did you hear about The Natural Way/ Who may we thank?

☐ Google	☐ Facebook	☐ Instagram	
☐Educational Talk	☐ Newsletter	☐ Yellow Pages	
☐ External Practitioner:	☐ Patient Referral:	☐ The Natural Way Staff:	☐ Other:
_____	_____	_____	_____

Occupation _____
Ethnic Background _____
Marital Status _____
DO YOU HAVE DIFFICULTY CLIMBING STAIRS? YES / NO

EMERGENCY CONTACT

Name: _____
Phone: _____
Relation: _____

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PRACTITIONER INFORMATION

Please list the names and contacts of your physician, and other Health Care Providers you are currently seeking treatment with:

Name:	1. _____	2._____	3._____
Telephone:	_____	_____	_____
Type of provider:	_____	_____	_____

(i.e. MD, Specialist, Chiropractor etc.)

FOR WOMEN:

Is it possible that you are currently pregnant? YES/NO
Are you currently breastfeeding? YES/NO

CHIEF COMPLAINT

What are your health concerns? (Please list in order of importance):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Chills and Fever

Do you ever have any of the following?
□ Chills □ fever □ both chills and fever
If so, please describe (how often, how long, time of day or circumstances, etc)
_____

Perspiration

Do you perspire? YES/NO
Do you perspire after heavy or slight exertion? _____
Any odours or colour to the perspiration? _____
Do you perspire at night? YES/NO
Do you perspire spontaneously? YES/NO

Head and Body

Do you experience headaches? YES/NO
If yes, when did the headaches begin? _____
What time of day do the headaches begin? _____
Where do the headaches occur (front, back, side of head, etc)? _____
_____
What is the character of the headache (sharp, dull, throbbing, etc)? _____

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Is there anything that makes the headaches better or worse (i.e., pressure, hot or cold applications, etc)? _____

_____

Do you ever experience dizziness? YES/NO
If yes, please describe _____

_____

Do you ever experience pain anywhere in your body? YES/NO
If yes, where? _____
How often? _____
Type of pain (dull, sharp, throbbing, etc) _____
Does the pain stay in one location or does it move around? _____
Does anything make it better or worse? _____
Do you have any other symptoms associated with the pain (fatigue, nausea, etc)?

_____

Do you ever experience pain in your joints? YES/NO

If yes, which joints? _____
How often? _____
Type of pain (dull, sharp, throbbing, heavy, etc)? _____

_____

Does the pain stay in one location or does it move around? _____

_____

Does anything make it better or worse? _____

_____

Do you ever experience swelling in your joints? YES/NO
If yes, which joints? _____
How often? _____
Is there any redness or heat in the joints that occurs with the swelling? YES/NO
Does anything make it better or worse? _____

_____

Do you ever experience back pain? YES/NO
If yes, Where? _____
How often? _____
Type of pain (dull, sharp, throbbing, etc) _____

_____

Does anything make it better or worse? _____

_____

Do you ever experience numbness anywhere in your body? YES/NO
If yes, Where? _____
How often? _____
Does anything make it better or worse? _____

Chest and Abdomen

Do have any chest pain? YES/NO
If yes, Where? _____

How often? _____
Type of pain (sharp, dull, crushing, heavy, aching, etc) _____
Does the pain radiate anywhere? _____
Does anything make it better or worse? _____
_____

Do you ever have palpitations? YES/NO
Do you ever have anxiety? YES/NO
Do you have asthma? YES/NO
Do you have a cough? YES/NO
If yes, What time of day does it occur? _____

Is the cough strong (hacking) or weak? _____
Is it wet or dry? _____
Do you have any phlegm/sputum with the cough? YES/NO
If yes, what is the colour and consistency (thick, watery, foamy, etc)? _____
_____

Do you have any difficulty breathing? YES/NO
If yes, please describe _____}_____
_____

Do you ever experience abdominal distension, pain, or a feeling of fullness in the abdomen? YES/NO
If yes, Where? (upper, lower, middle) _____ How often? _____
Does anything make it better or worse? (bowel movements, eating, etc)?
_____

If there is pain, describe the nature (sharp, dull, cramping) _____

Appetite, Thirst and Taste

How is your appetite? _____
Any changes in your appetite? _____

Any weight gain or loss? If so, please describe amount and over what period of time.
_____

How is your thirst? _____
How much water/fluid do you drink per day? _____
Any preference for hot or cold drinks? _____
Do you tend to sip or gulp your drinks? _____
Any particular food cravings? _____
Any feeling of fullness after meals? If so, where? _____
_____
Any unusual tastes in your mouth? (e.g., bitter, sweet, salty, etc) _____
Any bloating or gas? _____
Any belching, acid reflux, or vomiting? _____

Stool & Urine

Do you tend to be constipated or have diarrhea? _____
How many times per day do you have a bowel movement? _____
How many times per day do you urinate? _____
In terms of volume, is your urine scanty or profuse? _____
Is the colour of the urine clear, yellow, dark, or cloudy? _____
Any pain or difficulty with either urination or defecation? _____
What is the consistency of your stool (hard, formed, loose, watery, soft, dry, etc)?
_____

Any undigested food, mucous, or blood in the stool? _____

Sleep

Do you sleep well? YES/NO
On average, how many hours do you sleep per night? _____
Do you have any trouble falling asleep? _____
Do you have any trouble staying asleep? _____
Do you have trouble getting out of bed in the morning? _____
Do you frequently dream or have nightmares? _____

Ears & Eyes

How is your hearing? _____
Have you noticed any changes to your hearing recently? _____

Have you experienced deafness in either (specify) or both ears? _____
If yes, was the hearing loss sudden or gradual? _____

Do you ever experience ringing in either (specify) or both ears? _____
If yes, □ Is the ringing □ low-pitched? □ high-pitched?
Is the ringing □ constant? □ comes and goes?
Did the ringing □ begin suddenly? □ come on gradually?

Is there anything that makes the ringing better or worse (e.g., pressure? _____
_____
How is your vision? _____
Have you noticed any changes to your vision lately? _____
Do you ever experience
□ Blurred vision? □ Dry eyes?
□ Red eyes? □ Floaters?
□ Night blindness?

Menses and Leukorrhea (Females)

Is your period the same each month? YES/NO
How many days is your cycle? _____
How many days does your period last? _____
How many pad or tampons, on average, do you use per day during the heaviest days of your period? _____
What colour is your flow (dark red, bright red, brown, etc)? _____
Any clots in your period? YES/NO
Do you have or have you had vaginal discharge? YES/NO
If so, please describe the colour, consistency, and odour _____
_____

By signing this form, I certify that all of the information provided herein is complete and accurate to the best of my knowledge. If there are any changes to this information I will notify The Natural Way Health Clinic in a timely manner. I give permission to be contacted by The Natural Way Health Clinic as indicated in this form and for messages to be left at the indicated numbers. I give permission for an exchange of medical information to occur with those practitioners indicated within this form. I give permission for exchange of medical information to occur with other practitioners of The Natural Way Health Clinic, as needed for the purpose of consultation.

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Please list exceptions: _____

Name of Patient or Guardian: _____

Signature: _____ Date: _____

Doctor : _____ License # : _____

Signature: _____ Date: _____