

131 Union Street East,
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(T) 519-772-2116
(F) 886-731-5603
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
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? _____

Occupation _____

Ethnic Background _____

Marital Status _____

Do YOU HAVE DIFFICULTY CLIMBING STAIRS? YES / NO

EMERGENCY CONTACT

Name: _____

Phone: _____

Relation: _____

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.)

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FOR WOMEN:

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

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)? _____

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 _____

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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.

Please list exceptions: _____

Name of Patient or Guardian: _____

Signature: _____ Date: _____

Doctor : _____ License # : _____

Signature: _____ Date: _____