YONGE ♦ FINCH
CHIROPRACTIC
& HEALTH CENTRE

Shanti Ilo R.Ac
Acupuncturist

Confidential
Client Intake Form

Name (First/Last) _____ Gender: □M □F DOB(M/D/Y) _____

Address _____ City _____

Province _____ Postal Code _____ Email _____

T/Home (____) _____ T/Work (____) _____ T/Cell (____) _____ Marital Status □S □M □D □W

Employer Name _____ Occupation _____

Spouse's Name _____ Contact # (____) _____ Children: □Yes □No

Family Physician Name: _____ Contact # (____) _____

Emergency Contact Name _____ Contact # (____) _____

How did you hear about us? _____

PURPOSE OF VISIT

□ I have no concerns and feel well. I am interested in strategies and care that will optimize my health

Reason for your visit – main complaint _____

How long have you had this condition? _____ Onset: □ Gradual □ Sudden □ Trauma □ Other _____

Is your primary concern related to a motor vehicle accident? □ Yes □ No If YES, Date (M/D/Y) ____ / ____ / _____

Does your discomfort interfere with □ Work □ Sleep □ Daily Routine Explain _____

Have you had this discomfort before □ Yes □ No If yes, please explain _____

Does your discomfort interfere with □ Work □ Sleep □ Daily Routine Explain _____

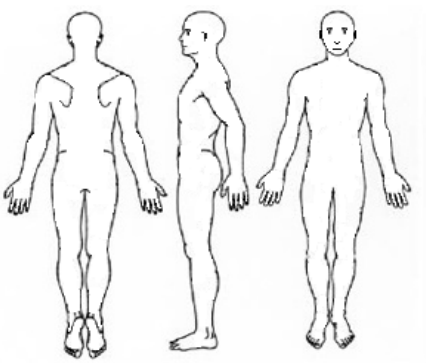
Who else have you seen for this? _____ How did you respond? _____

What did they do? _____

Have you completed any diagnostic imaging? _____

Results _____

Indicate in the pictures below the location(s) of your complaint(s)



Please rate your discomfort
(Circle) Least 0 1 2 3 4 5 6 7 8 9 10 Most

How often is the discomfort present?
□ Intermittent (25% or less) □ Occasional (25-50%) □ Frequent (50-75%) □ Constant (100%)

What makes your condition **BETTER**?
□ Lying down □ Sitting □ Standing □ Rest □ Exercise □ Nothing □ Other _____

What makes your condition **WORSE**?
□ Lying down □ Sitting □ Standing □ Rest □ Exercise □ Nothing □ Other _____

How would you characterize your discomfort?
□ Sharp □ Dull □ Ache □ Burn □ Throb □ Spasm □ Numb □ Tingling □ Shooting

Does your discomfort radiate into?
□ Does NOT radiate □ Arm □ Leg Explain:_____

Please list any previous injuries/surgeries/serious illnesses:

Injuries / Surgeries / Serious Illnesses	Date

Please list any medications you are currently taking and the condition(s):

Medication	Condition	Dosage

Have you taken any pain-killers, anti-inflammatory, muscle relaxants or mood altering medications in the past 2 hrs? □ Yes □ No If yes, what and dosage? _____

Experience with Acupuncture

Have you seen an Acupuncturist before? □ Yes □ No Date of last visit: ___ / ___ / _____ Frequency of visits ____ / wk

Reason for visits _____

How did you respond? _____

Have you tried other acupuncture modalities? □ Acupressure □ Laser □ auricular (ear) □ Other _____

Health Lifestyle

Do you exercise? □ Yes □ No How often/wk? □ 1X □ 2X □ 3X □ 4X □ 5X □ 6X □ 7X

What activities? □ Walking □ Running □ Cycling □ Weight Training □ Classes □ Yoga □ Other _____

Do you smoke? □ Yes □ No How much/wk? _____ Do you drink alcohol? □ Yes □ No How much/wk? _____

Do you drink coffee? □ Yes □ No How many cups/day? _____ How many hours do you sleep/night? _____

Do you take any supplements? (ie. vitamins, minerals, herbs) □ Yes □ No What? _____

_____

List 3 areas of nutrition you would like to improve 1) _____ 2) _____ 3) _____

Describe your job? □ Sedentary □ Active □ Physically demanding □ Other _____

How would you rate your stress level? (0=none – 10=extremely high) _____

List your 3 biggest sources of stress? 1) _____ 2) _____ 3) _____

Do you have any mental/spiritual practices? (ie. meditation, prayer) _____ How often/wk? _____

Overall, how is your general health? _____

Is there any additional information you would like to provide? _____

_____

_____

Signature: _____ Date (M/D/Y) ____ / _____ / _____