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NEW CLIENT INTAKE FORM
(Confidential)

Today's Date _____ Birthdate _____

Name _____

Address _____

City _____ Province/State _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email address: _____ Occupation _____

Emergency contact: Name _____ Phone: _____

Referred to Elizabeth Heffelfinger by _____

Have you received Acupuncture or Chinese herbs in the past? Yes No

Medical Doctor and other health care providers (naturopathy, osteopathy, chiropractic, acupuncture, massage therapy, physiotherapy, etc.)

_____

_____

Main Complaint – primary reason for your visit today: _____

_____

_____

Other health concerns:

_____ _____

_____ _____

Are you currently on medication? If so, what are you taking the medications for? (Example: high blood pressure, cholesterol, birth control, thyroid, heart, etc.)

_____ _____

_____ _____

_____ _____

Are you currently on any vitamin supplements, herbs or homeopathics? If so, what are you taking at the present time?

_____ _____
_____ _____
_____ _____

<u>Your Diet</u>

Appetite: Low High

Coffee Tea Artificial Sweetener Sugar Soft drinks Salty Food
Thirsty for water? Yes No How many glasses per day _____

Average Daily Menu

Morning	Afternoon	Evening	Snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Lifestyle

Alcohol Marijuana Stressful job/life
Tobacco Drugs
Regular Exercise No Yes Type _____ Frequency ____
Type _____ Frequency ____

General Symptoms (circle)

Poor sleep Body Heaviness Bleed/bruise easily
Heavy sleep Cold hands or feet Night sweats Sweat easily Cold or easily chilled
Strongly like cold drinks Strongly like hot drinks Recent weight loss/gain
Excessive fatigue Lack of strength Poor circulation Shortness of breath
Muscle cramps Vertigo or dizziness Peculiar taste (describe) _____

Gynecology (For Women Only): Are you currently pregnant? Yes No

Age menses began _____ Length of cycle *(ie. 30 days)* **_____**
Duration of flow _____ Irregular periods Painful periods PMS
Vaginal discharge Vaginal sores Vaginal odor Clots
Breast lumps # Pregnancies _____ # Live Births _____ Age at Menopause _____
Date of last PAP _____ Date last period began _____

Hospitalizations, operations, accidents, or conditions that are a significant part of your medical_____

_____

_____

PLEASE READ AND SIGN BELOW:

All information remains confidential. If any party wishes a copy of your files or any information therein, it will ONLY be given with the express written consent of YOU, the client.

_____ _____
Name **Date**