Lailee Mussivand RAc
Registered Acupuncturist, CTCMPAO
Sage Wellness | sagewellness.ca | 613 235 7243
340 Gladstone Ave - 2nd Floor | Ottawa, ON, K2P 0Y8

Acupuncture Intake Form

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential. For treatment purposes, information will be provided to another practitioner only upon patient consent.

Name: _____ Date: _____
Date of Birth: _____ Age: ____ Occupation: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: _____ Email: _____
Preferred way of contact: _____
Emergency Contact Name/Relationship: _____
Emergency Contact Phone: _____
Family Physician: _____ Marital Status: _____

Main Reason(s) for seeking treatment:

_____
_____
_____
_____
_____

Other therapies you have sought for treatment:

_____
_____

Please list all medications, vitamins, herbs & supplements and dosages:

_____
_____
_____

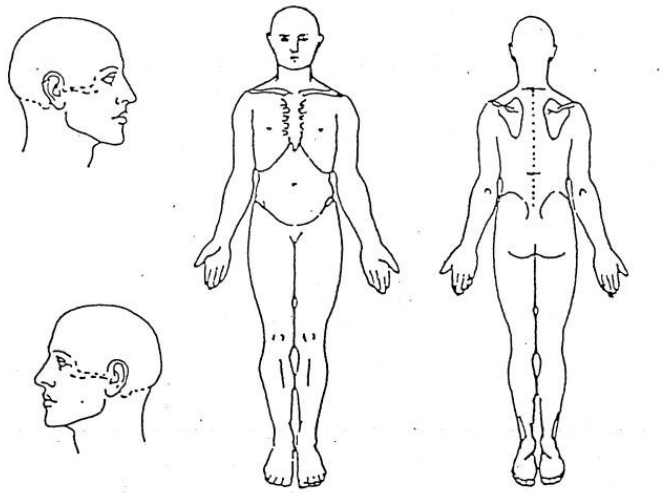
Please list allergies:

_____
_____

Please list surgeries:

_____
_____
_____

Please indicate any areas of pain or discomfort on the diagram:



If you have pain, indicate the severity on a scale of 1-10, 10 being unbearable: _____

Date this started: _____

Any known cause (i.e. trauma)?: _____

Personal Medical History (please check any conditions/symptoms you have or had):

- ☐ Pacemaker
- ☐ Surgery
- ☐ Asthma
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Seizures
- ☐ Stroke
- ☐ Cancer
- ☐ Eating Disorder
- ☐ Obesity
- ☐ Shingles
- ☐ STI
- ☐ Chronic Fatigue
- ☐ Heart Disease
- ☐ Multiple Sclerosis
- ☐ Hypo/Hyperthyroid
- ☐ Rheumatic fever
- ☐ Depression
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Stomach ulcers
- ☐ Pneumonia
- ☐ Other _____

Family Medical History (please check any that apply to your immediate family):

- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hypo/Hyperthyroid
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Other _____

_____

Date Signature of Patient/Representative