

Confidential Acupuncture Initial Assessment

Name: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Birthdate: (Day) _____ (Month) _____ (Year) _____

Occupation: _____ Home Phone: _____ Cell Phone: _____

Medical Doctor: _____ Doctor Phone #: _____

I agree that River Stone may notify me of new treatments and promotions via email. Yes No

How did you hear about us? (check one below)

Google
 Facebook
 Instagram
 Storefront Sign
 River Stone Therapist: _____
 World Weight Loss Inc.
 Doctor or lawyer: _____
 Other: _____

Main Concern: _____

Family History (Please check any appropriate boxes)						
Disease	Grandparent(s)	Father	Mother	You	Sibling(s)	Child(ren)
Hypertension						
Diabetes						
Cancer						
Thyroid Issue						
Kidney Issue						
Heart Issue						
Psychological Issues						

Do you have any medical conditions not listed above? Yes No

If yes, please describe: _____

Briefly list any surgeries you have undergone, for what and when.

Are you presently taking any prescribed medication(s)? Yes No

If yes, please record the medication(s) and the condition(s) for which it is being used if known.

Do you have any allergies? Yes No

If yes, please describe: _____

Pain	Area: _____ Rating 1-10 (10 most painful): _____ Describe the pain: sharp / dull / numb / distention / achy / heavy / heat / swollen
Food	Preference: sweet / sour / spicy / salty / bitter Preference: cold food / warm food Appetite: good / poor
Taste in the mouth when you wake up: sweet / sour / metal / salty / bitter / no taste	
Stools	constipated / dry / hard / pebble-like / sticky / loose / diarrhea / black / strong odour Frequency: _____ Other: stomach rumblings / flatulence / burning sensation
Urine	Colour: pale / light yellow / dark yellow / clear / cloudy / strong odour Amount & Frequency: _____
Thirst	In general: thirsty / not thirsty Preference: small sips / large gulps Preference: cold drink / warm drink
Energy	Energy level 1-10 (10 is most energetic): _____ In general: weary / sleepy / exhausted
Head	Headache: temporal / parietal / occipital / frontal Time of day: _____ Type: sharp / dull / numb / distention Heaviness of head / heat in face / dizziness / runny nose / facial pain / blurred vision / floaters Dry eyes / bleeding gums / mouth ulcers / tinnitus / hearing loss / deafness / ear pain
Trunk	Palpitations / pressure on chest / chest pain / epigastric pain / abdominal pain / hypogastric pain
Limbs	Weakness / numbness / joint pains / muscle aches / tremors / cold limbs / hot palms / heaviness
Sleep	Insomnia / wakefulness at night / dreams / wake up early and can't sleep / daytime lethargy
Sweat	Area: _____ oily / yellow / clear Time: _____ Quantity: light / profuse
Temp	Aversion to cold / hot Feverish
Emotion	Depression / fear / anxiety / irritability / worry / overthinking / sadness / grief
Sexuality	Low libido / high libido / headache after orgasm / impotence / premature ejaculation / STD
Periods	Early / late / irregular / heavy / scant / dark / bright / purple Amenorrhoea / menopause / leucorrhoea / infertility PMS: cramps / distention (breast, hypogastrium) / backache

I acknowledge that the Acupuncturist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that acupuncture therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge and understand that the Acupuncturist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Acupuncturist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Acupuncturist updated on my medical history. When treatment involves the use of heat lamps, I take the responsibility to keep the Acupuncturist advised as to whether any of the temperatures are uncomfortable, thereby releasing the Acupuncturist and River Stone Massage of any liability. I give consent for my treatment notes to be read by the other health care professionals at River Stone Massage. The information I have provided is true and complete to the best of my knowledge.

Signature

Date

Acupuncturist Signature