

## CROSS CURRENTS INTAKE

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Sex: female  male   
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ email: \_\_\_\_\_  
Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M  S  D  W   
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Specialists: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about us? friend  relative  health care referral  website   
From whom? \_\_\_\_\_

*Acupuncture is effective for a wide variety of health complaints, but it truly excels at wellness care. You need not have any particular complaints to receive acupuncture.*

What is your reason for this visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What (if any) medical diagnosis have you received: \_\_\_\_\_  
\_\_\_\_\_

What (if any) treatments have/are you receiving: \_\_\_\_\_  
\_\_\_\_\_

Please list all medications, herbs and supplements you are taking and their dosage:  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medicines or substances? If so, what? \_\_\_\_\_  
\_\_\_\_\_

Hospitalizations: *(list as best you can)*

Type of illness or operation/procedure

Date

Hospital

## EMOTIONS & SLEEP

How would you characterize your emotional life? \_\_\_\_\_


*Please check those that you currently experience, and underline those experienced in the past:*

- |                                     |   |   |   |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Poor memory      | <input type="checkbox"/> Panic attacks      | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fearfulness      | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Racing thoughts          |
| <input type="checkbox"/> Confusion  | <input type="checkbox"/> Frequent sighing | <input type="checkbox"/> Chest tightness    | <input type="checkbox"/> Worry                    |

Are you in a relationship? Yes  No

How do you feel about it? \_\_\_\_\_

How do you feel about work? Is it satisfying and rewarding; does it provide you with the necessities of life; is it just a job that you feel you must do in order to make a living? \_\_\_\_\_

How would you rate your stress level? Low  HIGH

How do you hold your stress? \_\_\_\_\_

How do you relax? \_\_\_\_\_

What time do you: Go to bed \_\_\_\_ am/pm Fall asleep \_\_\_\_ am/pm Get up \_\_\_\_ am/pm

How many hours of sleep to get? \_\_\_\_ Do you feel refreshed? \_\_\_\_\_

I have difficulty: (check any that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Falling Asleep   | <input type="checkbox"/> Staying Asleep | <input type="checkbox"/> Dream-disturbed Sleep              |
| <input type="checkbox"/> Recurrent dreams   | <input type="checkbox"/> Nightmares     | <input type="checkbox"/> Waking to urinate, ____ # of times |
| <input type="checkbox"/> Waking, with trouble falling back to sleep. What time? _____ |   |   |

## GASTROINTESTINAL

*Please check those that you currently experience, and underline those experienced in the past:*

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Bitter taste     | <input type="checkbox"/> Metallic taste       | <input type="checkbox"/> Sticky taste |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Gnawing hunger       | <input type="checkbox"/> Belching     |
| <input type="checkbox"/> Nausea           | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Heartburn    |
| <input type="checkbox"/> Indigestion      | <input type="checkbox"/> Vomiting of blood    | <input type="checkbox"/> Ulcers       |
| <input type="checkbox"/> Acid reflux      | <input type="checkbox"/> Food cravings, _____ |                                       |

Frequency of bowel movements: \_\_\_\_\_ x per day/week

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Irregular          |
| <input type="checkbox"/> Bloating         | <input type="checkbox"/> Cramping        | <input type="checkbox"/> Burning sensation  |
| <input type="checkbox"/> Loose stools     | <input type="checkbox"/> Hard stools     | <input type="checkbox"/> Painful to pass    |
| <input type="checkbox"/> Undigested food  | <input type="checkbox"/> Gas             | <input type="checkbox"/> Pellet-like stools |
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Strong odor        |

## FLUID METABOLISM & URINATION

How much liquid to you consume daily? \_\_\_\_\_. Are you thirsty?  Yes  No

What temperature of beverages do you prefer?  Hot  Cold  Room temperature

Please check those that you currently experience, and underline those experienced in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Night sweating                         | <input type="checkbox"/> Sweaty palms     |
| <input type="checkbox"/> Yellow sweating (can be noticed as stains on armpits and neckline of clothing) |   |   |
| <input type="checkbox"/> Frequent urination   | <input type="checkbox"/> Incontinence                           | <input type="checkbox"/> Kidney stones    |
| <input type="checkbox"/> Burning urination  | <input type="checkbox"/> Urinary tract infection                | <input type="checkbox"/> Cloudy urination |
| <input type="checkbox"/> Blood in urine   | <input type="checkbox"/> Weak urine stream, or trouble starting |   |

## EARS, EYES, NOSE, THROAT & HEAD

Do you experience headaches/migraines?  Yes  No. How often? \_\_\_\_\_

Where are these headaches located?

- |   |                                      |                                   |  |
|---|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Unilateral     | <input type="checkbox"/> Bilateral   | <input type="checkbox"/> Temples  | <input type="checkbox"/> Behind eye(s) |
| <input type="checkbox"/> Occipital/neck | <input type="checkbox"/> Top of head | <input type="checkbox"/> Forehead | <input type="checkbox"/> Whole head    |
| <input type="checkbox"/> Sinuses        | <input type="checkbox"/> Fixed spot  | <input type="checkbox"/> Moving   |  |

What type of pain do they present with?

- |  |                                    |  |   |
|--|------------------------------------|--|---|
| <input type="checkbox"/> Boring/stabbing | <input type="checkbox"/> Dull/achy | <input type="checkbox"/> Throbbing         | <input type="checkbox"/> Wrapped up feeling |
| <input type="checkbox"/> Full            | <input type="checkbox"/> Empty     | <input type="checkbox"/> Stiffness/pulling | <input type="checkbox"/> Bursting           |

What makes them better? \_\_\_\_\_

What triggers or aggravates them? \_\_\_\_\_

Do you smoke?  Yes  No \_\_\_\_\_ /day for \_\_\_\_\_ years. Date quit \_\_\_\_\_

How many times per year do you catch colds/flu's? \_\_\_\_\_. What kind? (e.g. common cold, influenza, intestinal flu, or other) \_\_\_\_\_

How would you characterize your body temperature?  Hot  Cold  Neither

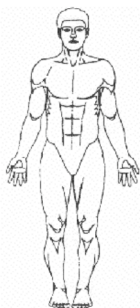
Does this change at different times of the day?  Yes  No. How? \_\_\_\_\_

Please check those that you currently experience, and underline those experienced in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chills           | <input type="checkbox"/> Fever              | <input type="checkbox"/> Alternating chills & fever |
| <input type="checkbox"/> Chronic cough    | <input type="checkbox"/> Nose bleeds        | <input type="checkbox"/> Bleeding gums              |
| <input type="checkbox"/> Canker sores     | <input type="checkbox"/> Cold sores         | <input type="checkbox"/> Dry mouth                  |
| <input type="checkbox"/> Sore throat      | <input type="checkbox"/> Dry throat         | <input type="checkbox"/> Lump in throat             |
| <input type="checkbox"/> Excessive mucous | <input type="checkbox"/> Bad breath         | <input type="checkbox"/> Dry eyes                   |
| <input type="checkbox"/> Red/painful eyes | <input type="checkbox"/> See spots/floaters | <input type="checkbox"/> Ear pain                   |
| <input type="checkbox"/> Blurred vision   | <input type="checkbox"/> Dizziness/vertigo  | <input type="checkbox"/> Ear ringing                |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Facial palsy/tic           |

## MUSCULOSKELETAL

What type of pain do you experience? Please mark '1' for mild, '2' for moderate and '3' for severe.



- |                    |                   |                      |
|--------------------|-------------------|----------------------|
| ___ Wandering pain | ___ Fixed pain    | ___ Superficial pain |
| ___ Deep pain      | ___ Stabbing pain | ___ Pricking pain    |
| ___ Burning pain   | ___ Shooting pain | ___ Sharp pain       |
| ___ Dull pain      | ___ Aching        | ___ Gripping pain    |
| ___ Numbness       | ___ Tingling      | ___ Pins & needles   |

What makes the pain better or worse? (Mark those factors that make the pain better with a 'B', and those that make the condition worse with a 'W')

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Application of cold         | <input type="checkbox"/> Application of heat | <input type="checkbox"/> Application of pressure |
| <input type="checkbox"/> When resting                | <input type="checkbox"/> When active         | <input type="checkbox"/> When tired              |
| <input type="checkbox"/> When under stress           | <input type="checkbox"/> Upon waking         | <input type="checkbox"/> In the evening/night    |
| <input type="checkbox"/> Other, please explain _____ |  |  |

## FEMALE REPRODUCTIVE

Please check those that you currently experience, and underline those experienced in the past:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Lumps in breast          | <input type="checkbox"/> Nipple discharge         | <input type="checkbox"/> Breast pain             |
| <input type="checkbox"/> Pelvic pain              | <input type="checkbox"/> Vaginal discharge        | <input type="checkbox"/> Vaginal itching/burning |
| <input type="checkbox"/> Unpleasant odor          | <input type="checkbox"/> Genital eruptions        | <input type="checkbox"/> Painful sex             |
| <input type="checkbox"/> Lack of sexual desire    | <input type="checkbox"/> Excessive sexual desire  | <input type="checkbox"/> Menstruation absent     |
| <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Clotting in menstruation | <input type="checkbox"/> Heavy menstruation      |

Are you sexually active?  Yes  No. Do you use birth control? \_\_\_\_\_

Have you ever used birth control pills?  Yes  No. How long? \_\_\_\_\_

Age of first menstruation: \_\_\_\_\_ Periods occur every \_\_\_\_\_ days, and last \_\_\_\_\_ days.

Are your periods regular?  Yes  No. Date of last period: \_\_\_\_\_

Please indicate any of the following that you experience, and underline those that you have experienced in the past. Mark 'B' for before, 'D' for during, and 'A' for after your period.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Mood changes       | <input type="checkbox"/> Irritability/anger           | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Crying                       | <input type="checkbox"/> Forgetfulness   |
| <input type="checkbox"/> Clumsiness         | <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Dizziness/faint |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Increased appetite           | <input type="checkbox"/> Sweet cravings  |
| <input type="checkbox"/> Weight gain        | <input type="checkbox"/> Breast tenderness            | <input type="checkbox"/> Back pain       |
| <input type="checkbox"/> Cramping           | <input type="checkbox"/> Other (please specify) _____ |  |

Have you had in the past, or do you currently experience problems with fertility? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_ # of pregnancies    \_\_\_\_\_ # of births    \_\_\_\_\_ # of miscarriages    \_\_\_\_\_ # of abortions

Any complications of pregnancy?  Yes  No If yes, please explain \_\_\_\_\_

## MALE REPRODUCTIVE

Are you sexually active?  Yes  No. Do you use birth control? \_\_\_\_\_

Please check those that you currently experience, and underline those experienced in the past:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Vasectomy        | <input type="checkbox"/> Prostate problems               | <input type="checkbox"/> Male infertility    |
| <input type="checkbox"/> Painful erection | <input type="checkbox"/> Difficult/premature ejaculation | <input type="checkbox"/> Erectile difficulty |
| <input type="checkbox"/> Penile discharge | <input type="checkbox"/> Swelling, lumps, pain in testes | <input type="checkbox"/> Other _____         |

Date of last prostate exam: \_\_\_\_\_.