Celina Lyons, L.Ac

(250) 896-6332 ocean@celinalyons.com

INTAKE FORM

Welcome to the clinic, thank you for taking the time to fill out this form.
(All information is strictly confidential.)

Date_____

Patient's Name _____

Mailing address_____

Home Tel. #_____ Cell #_____ Email _____

Date of birth _____ Age _____ Sex _____ Weight _____ Height _____

Marital status _____ Spouses Name _____

If under 18 years of age, who authorizes treatment? _____

Mother's name _____ Father's name _____

Emergency Contact _____ Relationship _____

Phone_____ Referred by _____

Employment information:

Occupation _____ Work address _____

Work phone _____ Work email _____

If someone other than the patient is responsible for payment, please fill in this section.

Name _____

Address _____ Phone _____

I authorize Celina Lyons, a Registered Acupuncturist, to give me treatment. I understand that I am responsible for payment of all treatment costs. I authorize Celina Lyons to release all medical information acquired from my examination, illness or treatment for purposes of claims administration and evaluation, utilization review and financial audit.

I will call and cancel 24 hours in advance if I am unable to keep my appointment, or I will be held financially responsible for my missed appointment.

Signed _____ Date _____
(parent or guardian if minor)

Cont'd on next page

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PERSONAL HISTORY

Name _____ Age _____ Date _____

Please give a brief description of your present illness or health condition:

_____

_____

_____

Do you have a major adult love relationship?_____

In general;

Are you hot, or cold? _____ Are you thirsty? _____

What do you like to drink? _____

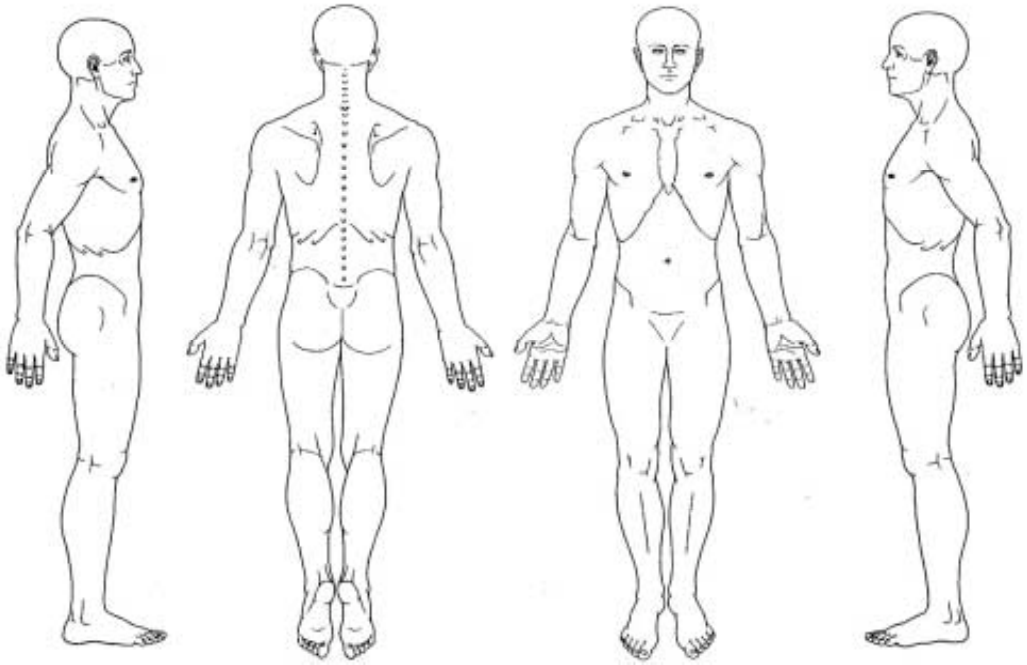
Do you sweat at night? _____ In the day time? _____

Do you get headaches? _____ Dizziness? _____

Disturbances in vision? _____

Musculoskeletal: Are you currently in any pain? _____

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



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PERSONAL HISTORY

How many bowel movements per day? _____ Are they formed? _____

Do you urinate often during the day? _____ At night? _____

Frequency during the night? _____

Do you breathe with difficulty upon slight exertion? _____

Do you exercise? _____ Describe. _____

Do you sleep well and easily? _____ How many hours? _____Bed time at: _____

Do you feel that you have a good immune system? _____

Do you cough up sputum? _____ If so, what color and texture? _____

Please list all medical drugs you are currently taking: _____

_____

Do you have a history of many drugs used during childhood? _____

Do you drink alcohol? _____ If so, how much and how often? _____

Do you smoke? _____ Amount? _____ Have you had hepatitis? _____

List all severe illnesses, give dates _____

_____

_____

List all chronic illnesses _____

_____

_____

List and date any surgeries or hospitalizations _____

_____

Do you have any history of mental illness? _____

What negative emotion best suits you? (Example, anger, fear, grief, over-thinking, worrying, excess joy, depression, irritability) _____

Do you have low back pain? _____ Ringing in the ears? ____ Dry eyes? _____

Sore joints? _____

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PERSONAL HISTORY

FOR WOMEN:

Onset of menses at what age? _____ Normal cycle is _____ days.

History of birth control _____

Current method of contraception? _____

Are you currently pregnant? _____ How many pregnancies? _____Which years? ____

How many full term babies? _____

Miscarriages _____Years _____ Therapeutic abortions _____Years _____

PID _____ Treatment _____ Irregular menses _____ When? _____

Positive Paps? _____ Breast lumps? _____

SYMPTOMS:

Check all below that apply, both past and present history

GENERAL
___ cold fingers/toes
___ Excessive or spontaneous sweating
___ night sweats
___ sleep problems
___ strong thirst
___ arthritis
___ fatigue
___ feeling run down
___ skin problems
___ catch colds easily
___ bad breath
___ sexual dysfunction
___ hemorrhoids
___ vomiting

HEAD
___ headache / migraine
___ head feels heavy
___ dizziness
___ seizures
___ jaw tension/pain

CHEST
___ high / low blood pressure
___ chest pain
___ cough / wheezing / asthma
___ phlegm
___ palpitations
___ shortness of breath

DIGESTION
___ nausea / vomiting
___ stomach pain
___ gas
___ bloating
___ constipation
___ diarrhea
___ indigestion
___ changes in appetite

FEMALE
___ PMS
___ irregular periods
___ leukorrhea
___ cramping / pain
___ fibroids / cysts
___ menopausal symptoms

GENITOURINARY
___ urinary difficulty
___ frequent urination
___ incontinence
___ pain/pressure/burning
___ UTI s
___ yeast infection(s
___ pain/itching of genitals
___ impotence

MENTAL / EMOTIONAL
___ nervousness
___ tension/anxiety
___ irritability
___ depression
___ antidepressants

INFECTIOUS DISEASE
___ TB
___ HIV
___ Hepatitis B/C
Other:
_____
_____
_____
_____