Dr. Tahmineh Nikookar

CONFIDENTIAL PATIENT INTAKE FORM

Personal Details

First Name: _____ Last Name: _____

Date of Birth: _____ Sex: M: ___ F: ___

Occupation: _____ Height: _____ Weight: _____

Contact Information

Address: _____

City: _____ Province: _____Postal Code: _____

Primary Phone:_____Secondary Phone:_____

Email:_____

Emergency Contact: Name:_____Phone:_____
Relationship to you: _____

Personal Information

Family physician: Name: _____ Phone number: _____

Marital status: Single: ___ Married: ___ Widowed: ___ Common law: ___Other:____

Do you have any children? Yes __ No __ How many? _____

Are you pregnant: Yes __ No __

Menstrual Period:

Do you menstruate regularly? Yes __ No __

Flow: Heavy___ light: ___ Painful Periods: Yes __ No __ PMS: Yes __ No _

Any concerns please explain: _____

Do you do any kind of exercise? Yes __ No __ how often? _____
Type of exercise: _____Your energy level: _____

How many cups of coffee of you drink per day: _____

How many glasses of water do you drink per day: _____

How many glasses of alcohol do you drink per week: _____

Do you smoke: Yes __ No __ If yes, how many per day: _____

Do you use street drugs: Yes __ No __ If yes, please provide the amount and the name of the drug: _____

Taste preference: Salty: ____Sweet: _____ Spicy: _____ Sour: ____Bitter: _____

Have you had any major car accident(s)? Yes __ No __ If yes, indicate injuries and dates: _____

Have you had a fracture/stress fracture? Yes __ No __ If yes, please indicate injury and dates:

Have you had any surgical procedures? Yes __ No __ If yes, please indicate where and with dates:

_____
_____

MEDICAL HISTORY:

Have you had acupuncture before? Yes __ No __
If yes, for what reason: _____

Are you currently receiving any type of treatment for a condition? Yes __ No __ if yes, please explain the ailment, treatment, and treatment frequency: _____
_____
_____

Have you been given a medical diagnosis by a Physician: Yes: ____ No: ____

If yes, please specify: _____

Cause of present discomfort or disability: _____
_____

Are you currently taking any medications? Yes __ No __ If yes, please list and specify for what medical conditions: _____
_____

Are you taking any herbal preparations, supplements, vitamins, or homeopathic remedies? Yes __ No __ If yes, please list: _____
_____
Are you currently under medical treatment for any condition? Yes __ No __ If yes, please specify: _____

Do you currently or have you ever had any of the following:

	T.B.	If yes, provide date:	
	HIV positive	If yes, provide date:	
	Type 1 diabetes	If yes, how long:	
	Type 2 diabetes	If yes, how long:	
	High blood pressure	If yes, how long:	
	Low blood pressure	If yes, how long:	
	Heart palpitations	If yes, how long:	
	Irregular heart beat	If yes, how long:	
	pace maker	If yes, how long:	
	Hepatitis	If yes, provide date and duration:	
	Herpes		
	Anemia	If yes, how long:	

Do you have any allergies? Yes __ No __ If yes, please list_____

Do you suffer from arthritis? Yes __ No __ If yes: Please explain where and your level of discompfort:
_____

Do you experience any numbness: Yes __ No __ Tingling: Yes __ No __
If yes, please explain where: _____
_____

Have you ever had any major illness? Yes __ No __ If yes, indicate dates:

Have you ever had cancer: Yes__ No___ If yes, please indicate dates:
_____

Do you have a family history of cancer: Yes__ No___

Have you ever experienced an epileptic seizure or been informed you might have epilepsy? Yes __ No __ If yes, please explain: _____
_____

Do you have any skin problems? Yes __ No __ If yes, please specify: _____
_____

Do you have recurrent ear problems: Yes___ No___ If yes, please explain:
_____

Bowel Movements

Regular: Yes __ No __ Normal: Yes __ No _ Daily: Yes __ No __

Urination

Incontinence: Yes __ No __ Frequent urination: Yes __ No __
Colour: Light: ____ Dark: ____ Burning sensation: Yes __ No __
Pain: Yes __ No __ Bladder infection: Yes __ No __
_____

Digestion

Acid reflux: Yes __ No __ Bloating: Yes __ No __
Diarrhea: Yes __ No __ Constipation: Yes __ No __
Other: _____

Are you suffering from frequent headaches? Yes __ No __ please specify:

Do you have frequent congestion? Yes No Please explain:

Sleeping disorders

Insomnia: Yes __ No __
Interrupted sleep: Yes __ No __
Sleep walking: Yes __ No __

Are you currently under stress? Yes __ No __ If yes, please specify the level of stress: Low, medium or high: _____

Are you suffering from depression, anxiety or panic attacks? Yes __ No __ If yes, please specify. _____

Aches and Pains

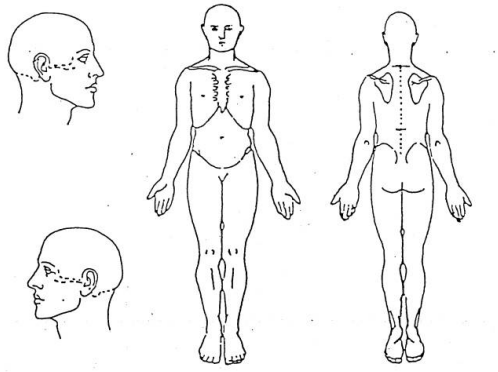
Do you have any aches or pains: Yes __ No __ If yes, please check all that apply.

Head: ____Neck: ____Upper shoulders: ____Mid back: _____Lower back: _____
Shoulder joints: _____Elbows:_____Wrists: _____Hip joint:_____Knees _____Ankles _____Other_____

What aggravates the pain: Weather:__Heat:__ Cold: __Pressure:__Other:

Pain sensation:

Sharp: Tingling: Burning: Dull: Moving: Severe: Shooting pain: Numbness:



What is the level of pain?

No Pain **1 2 3 4 5 6 7 8 9 10** High pain level

Do you have any other health concerns? Yes __ No __ if yes; please explain.

How did you hear about us?_____
