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)

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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? _____

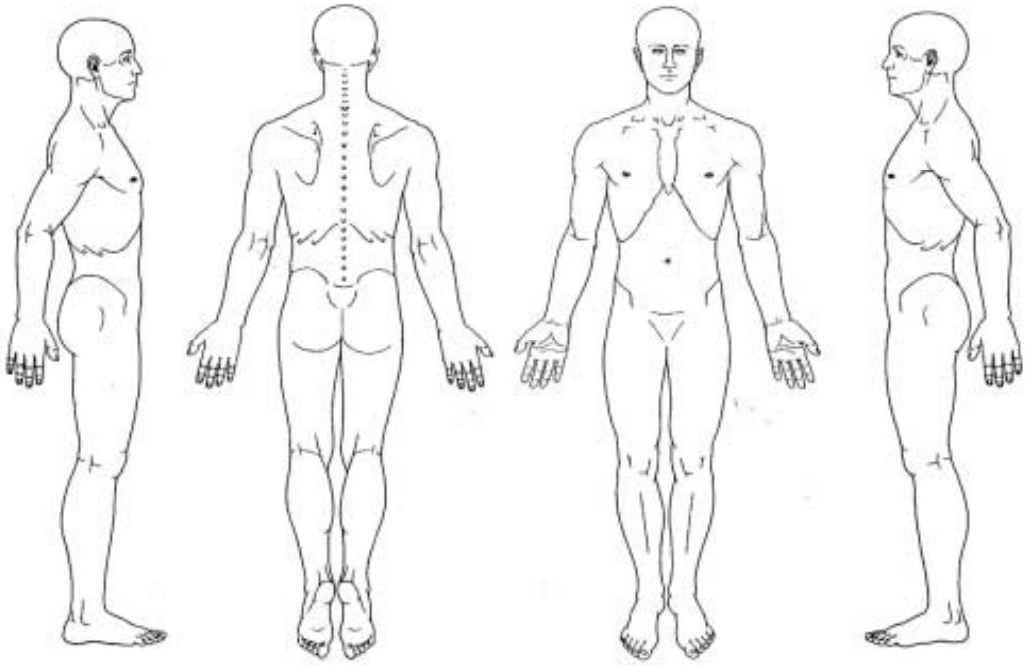
Do you sweat at night? _____ In the day time? _____

Do you get headaches? _____ Dizziness? _____

Disturbances in vision? _____

Musculoskeletal: Are you currently in any pain? _____

Please CLICK, TAP, or mark all 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:
_____
_____
_____
_____