Markham Family Chiropractic & Physiotherapy
121 Main Street N.
Markham, ON, L3P 1Y1
905-472-0082

Patient Intake form for TCM Acupuncture Treatment

Patient Information		
First Name / Last Name		Contact Phone
Email		Birth Date:
Home Address		
Occupation:	Family Doctor/ Phone:	
Emergency Contact information	Phone	Relationship

Medical History

Surgeries , if any, dates and types _____

_____

Injuries, if any, dates and types

_____

Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/ Long Term Treatment

Current Medications , if any, types and dosage : _____

_____

Supplements, Herbs, if any ; _____

_____

Allergies , if any; _____

Are you receiving treatments from other health professionals (e.g.. physiotherapist, chiropractor)

_____

Any Pacemakers, Metal -implants. Pins , Wires, : YES / NO

Please check any conditions that you have / are experiencing:

General Symptoms	**Pain in Muscles and Joints**	**Cardiovascular**
Headaches/migraines	Neck	High blood pressure
Excessive Chills or Sweat	Upper Back	Low Blood Pressure
Memory loss	Mid/ Lower Back	High cholesterol
Dizziness/Light headiness	Shoulders	Stroke
Fainting	Gluteal Region	Chest Pain
Stress/depression	Knees	Shortness of breath
Nervousness	Foot / Ankle	High Cholesterol
Recent weight loss/gain	Hand/ Fingers/ Wrist	Varicose Veins
Respiratory	**Genitourinary System**	**Ears, Eyes, Nose, Throat**
Chronic cough	Blood in urine/stool	Hearing loss
Spitting up phlegm	Kidney stone/ Kidney infection	Ringing in ears
Asthma	Bladder infection	Eye pain
Difficulty breathing	Inability to control urine	Ear discharge
		Earache
Skin	**GasatroIntestinal**	Sore throat
Skin conditions/rashes / excessive dryness	Distress from greasy foods	
Allergies/ Hives	Excessive hunger/thirst	
Bruise Easily	Belching or gas	
Eczema	Poor Appetite	
	Vomiting	
For Women Only	Burning in stomach	
Cramps/backache	Pain over stomach	
Previous miscarriage	Constipation/diarrhea	
Irregular cycle Vaginal discharge	Colitis	
Lumps in breast	Liver trouble/hepatitis	
Menopausal symptoms	Gall bladder	
Pregnant Due Date:	Ulcers Hemorrhoids	
Hysterectomy		

Please Circle if you have/ had any of the following

Appendicitis	**Arthritis**	**Chicken pox**	**Alcoholism**	**Osteoporosis**
Diabetes	**Venereal infection**	**Gout**	**Cancer**	**Whooping Cough**
Epilepsy	**Multiple sclerosis**	**Anemia**	**HIV/AIDS**	**Tuberculosis**
Pneumonia	**Measles**	**Goiter**	**Parkinson's**	

Date _____ Patient Signature _____

1st update _____ 2nd Update _____