Date ___________________

Confidential Acupuncture Initial Assessment

Name: ____ ❐ Male ❐ Female

Address: ______________________ City: _______________ Postal Code: __________

Email: ____________________________ Birthdate: (Day)______ (Month)_______ (Year)_______

Occupation: _______________ Home Phone: ____________ Cell Phone: ______________

Medical Doctor: ______________________ Doctor Phone #: ______________________

I agree that River Stone may notify me of new treatments and promotions via email. ❐ Yes ❐ No

Main Concern: ____

____

____

Family History (Please check any appropriate boxes)						
Disease	Grandparent(s)	Father	Mother	**You**	Sibling(s)	Child(ren)
Hypertension						
Diabetes						
Cancer						
Thyroid Issue						
Kidney Issue						
Heart Issue						
Psychological Issues						

Do you have any medical conditions not listed above? ❐ Yes ❐ No

If yes, please describe: ____

Briefly list any surgeries you have undergone, for what and when.

____

____

Are you presently taking any prescribed medication(s)? ❐ Yes ❐ No

If yes, please record the medication(s) and the condition(s) for which it is being used if known.

____

____

Do you have any allergies? ❐ Yes ❐ No

If yes, please describe: ____

Pain	Area: ____________________ Rating 1-10 (10 most painful): ___________ Describe the pain: sharp / dull / numb / distention / achy / heavy / heat / swollen
Food	Preference: sweet / sour / spicy / salty / bitter Preference: cold food / warm food Appetite: good / poor
Taste in the mouth when you wake up: sweet / sour / metal / salty / bitter / no taste	
Stools	constipated / dry / hard / paddle-like / sticky / loose / diarrhea / black / strong odour Frequency: Other: stomach rumblings / flatulence / burning sensation
Urine	Colour: pale / light yellow / dark yellow / clear / cloudy / strong odour Amount & Frequency:
Thirst	In general: thirsty / not thirsty Preference: small sips / large gulps Preference: cold drink / warm drink
Energy	Energy level 1-10 (10 is most energetic): _______ In general: weary / sleepy / exhausted
Head	Headache: temporal / parietal / occipital / frontal Time of day:________ Type: sharp / dull / numb / distention Heaviness of head / heat in face / dizziness / runny nose / facial pain / blurred vision / floaters Dry eyes / bleeding gums / mouth ulcers / tinnitus / hearing loss / deafness / ear pain
Trunk	Palpitations / pressure on chest / chest pain / epigastric pain / abdominal pain / hypogastric pain
Limbs	Weakness / numbness / joint pains / muscle aches / tremors / cold limbs / hot palms / heaviness
Sleep	Insomnia / wakefulness at night / dreams / wake up early and can't sleep / daytime lethargy
Sweat	Area: ___________________ oily / yellow / clear Time: __________ Quantity: light / profuse
Temp	Aversion to cold / hot Feverish
Emotion	Depression / fear / anxiety / irritability / worry / overthinking / sadness / grief
Sexuality	Low libido / high libido / headache after orgasm / impotence / premature ejaculation / STD
Periods	Early / late / irregular / heavy / scant / dark / bright / purple Amenorrhoea / menopause / leucorrhea / infertility PMS: cramps / distention (breast, hypogastrium) / backache

I acknowledge that the Acupuncturist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that acupuncture therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge and understand that the Acupuncturist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Acupuncturist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Acupuncturist updated on my medical history. When treatment involves the use of heat lamps, I take the responsibility to keep the Acupuncturist advised as to whether any of the temperatures are uncomfortable, thereby releasing the Acupuncturist and River Stone Massage of any liability. I give consent for my treatment notes to be read by the other health care professionals at River Stone Massage. The information I have provided is true and complete to the best of my knowledge.

Signature ______________________ Date ____________ Acupuncturist Signature ______________________