File #_____

MYO CENTRE INC.
Massage Therapy & TCM Acupuncture

Acupuncture Intake Form

Name……Date of Birth……

Address……City……Postal Code……..

Phone …… Email……..

Family Doctor…… Occupation…….

Medications……..

Other treatments undergoing……..

HEALTH HISTORY

Please list your health concerns in order of importance:

……

Any surgeries or hospitalized history?

……

Any hypersensitivity/allergy to food, medications, herbs?

……

Any history of fainting? **Yes** ☐ **No** ☐ Is your visit today the result of an injury or accident? **Yes** ☐ **No** ☐

Please give a **24 hour notice for ALL CANCELLATIONS** so we can fill that empty spot. It is our Policy to **CHARGE 50%** of your booked treatment if you do not give us the fore mentioned notice.

We offer **EMAIL REMINDERS** only of your appointments direct to your PC or Smart Phone

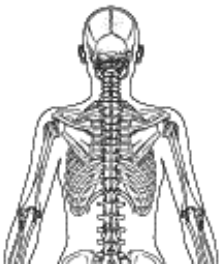
Please **CANCEL** appointments **ONLINE** **Call** 780 451-9290 or **Email** myoctr@telus.net

I, the undersigned, hereby certify that all the information on this form is complete and accurate. I agree to pay MYO CENTRE INC. all outstanding monies owing for acupuncture treatments received at the above mentioned clinic, should my insurance company not pay within 90 days of the original invoice date. I give my permission to receive acupuncture treatments. I have read the above information and agree to its conditions.

Permission to contact you? **Yes** ☐ **No** ☐

Signature……Date……

How did you hear about us?_____



List of Current Problems

Date:	**Name:**		**Tx #:**		
Mood swings	Y	N	Joints(elbow,ankle,shoulder,small joints) pain/ache	Y	N
Depression	Y	N	Knee pain/weak	Y	N
Anxiety, Nervousness	Y	N	Night sweats	Y	N
Stress, Tension	Y	N	Easy perspiration	Y	N
Insomnia	Y	N	Blurred vision	Y	N
Fatigue/tiredness	Y	N	Eye pain, dry, tearing	Y	N
Memory problem	Y	N	Ear ringing(frequent)/ache	Y	N
Dizziness	Y	N	Hearing loss	Y	N
Headache	Y	N	Frequent colds/Flu	Y	N
Chill	Y	N	Sinus problem	Y	N
Fever	Y	N	Painful Urination	Y	N
Skin problem	Y	N	Incontinence urination	Y	N
Lumps	Y	N	High/low blood pressure	Y	N
Sore throat	Y	N	Angina or Chest pain	Y	N
Swollen glands	Y	N	Palpitations	Y	N
Cough	Y	N	Abdominal pain/cramps	Y	N
Short of breath	Y	N	Digestive disorders: Nausea/vomit	Y	N
Edema/swelling	Y	N	Poor appetite	Y	N
Blood in stools	Y	N	Constipation	Y	N
Hemorrhoids	Y	N	Diarrhea/loose stools	Y	N
Spasms	Y	N	Alternative bowel mvt	Y	N
Upper back pain	Y	N	Easy bleeding/bruising	Y	N
Low back pain	Y	N	Fainting	Y	N
FOR MALES ONLY					
Testicular pain	Y	N	STD	Y	N
impotence	Y	N	Prostate problem	Y	N

FOR FEMALES ONLY					
Age of first menses					
Length of cycle	days		Duration of menses	days	
Painful menses	Y	N	Heavy excessive flow	Y	N
PMS	Y	N	Regular cycles	Y	N
Pregnant	Y	N	Discharge	Y	N
Bleeding/spotting between cycles	Y	N	Problems in pregnancy	Y	N
Birth control	Y	N	Menopausal problem	Y	N
Number of pregnancies	Y	N	Breast lumps	Y	N
Problems in delivery	Y	N	STD	Y	N