Temple Crossing Chiropractic and Massage
204 – 5401 Temple Drive NE
(403) 280-8992 / (403) 293-1288
www.templechiro.com

ACUPUNCTURE AND TCM HISTORY INTAKE FORM

Last Name ______________________ First Name ______________________
Address ______________________ Birthday ______________
Street City D/ M/Y

______________Phone (Home)__________(Work)__________(Cel)__________
Province Postal Code

Email Address ______________________
Occupation ______________________
Emergency Contact ______________________ Phone ______________
Doctor's Name ______________________ Phone ______________

NOW: □ PREGNANT □ PACEMAKER □ HIV DISEASE □ HEPATITIS □ BLOOD TRANSFUSION

FAMILY HISTORY:

□ Abuse □ AIDS □ Alcoholism □ Allergies □ Asthma □ Cancer □ Chemical Dependency □ Diabetes
□ Heart Disease □ High Blood Pressure □ Mental Illness □ Respiratory Diseases □ Seizures □ Stroke
□ Other ______________________

YOUR PAST MEDICAL HISTORY/ILLNESSES: □ Other:

□ Aids/HIV □ Alcoholism □ Allergies □ Anemia □ Arthritis □ Asthma □ Auto Immune Disease □ Bleeding Disease
□ Breast Cysts □ Bi Polar □ Bronchitis □ Cancer □ Candida (Yeast) □ Chemical Dependency □ Chronic Fatigue Syndrome
□ Chronic Lung Disease □ Colitis □ Diabetes □ Eating Disorder □ Fracture □ Glaucoma □ Gall Stones □ Gout
□ Headaches □ Heart Disease □ Hepatitis □ Hernia □ Herniated disc □ High Blood Pressure □ High Cholesterol
□ Kidney Disease □ Liver Disease □ Low blood pressure □ Migraine □ Mononucleosis □ Multiple Sclerosis
□ Mental Illness □ Osteoporosis □ Organ Transplant □ Parkinson's □ Pneumonia □ Prostate problems □ Rheumatic Fever
□ Seizures/Epilepsy □ Sexually Transmitted Diseases (STD) □ Stroke □ Substance Abuse/Addiction □ Suicide attempt
□ Thyroid Disease □ Tuberculosis □ Ulcers □ Vaccine Reaction □ Whooping Cough

SURGERIES: (Please include dates and if any complications)

1______________________ 2 ______________________
3______________________

TRAUMATIC INJURY: (Please include dates and if any complications)

Car accident(s) ______________________
Fall(s) ______________________
Other ______________________

ALLERGIES

CURRENT MEDICATIONS:

HABITS/EXCESSIVE USAGE: (Please tell us how often & how much)

□ alcohol________ □ cigarettes ________ □ coffee ________ □ exercise________ □ salt ________ □ sugar __________ □ tea _________
□ water _________ □ other _________ .

CHIEF COMPLAINT / REASON FOR YOUR VISIT:

How and when did this condition begin?______________________
Please list your main health concerns you would like to be free of, in order of importance:

1. ______________________2.______________________