



Michael Cote, R.Ac

Acupuncturist / Traditional Chinese Medicine

Patient Intake Form

Last Name: \_\_\_\_\_ Given Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of birth  
(MM/DD/YY): \_\_\_\_\_ Age: \_\_\_\_\_

Care Card #: \_\_\_\_\_ Sex:  M /  F

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Other: \_\_\_\_\_

E-mail: \_\_\_\_\_

May I leave messages relating to your visits?  Yes  No

Emergency contact:  
\_\_\_\_\_

Phone number: (\_\_\_\_) \_\_\_\_\_ Relation:  
\_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about the clinic?  
\_\_\_\_\_

Have you ever been hospitalized or had surgery?  Yes  No

**Achieve Health**  
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107-1505 Admirals Road, Victoria, BC V9A 2P8  
Tel: (250) 384-5211 Fax: (250) 388-6121  
www.achievehealth.ca

If so, when was it and what was the reason?

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Are you currently taking medication or supplements of any kind?  Yes  No  
If so, please list them:

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Do you have any allergies (environmental, foods, medicines, etc) ?  Yes  No  
If so, please list them:

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For women:

Are you pregnant now?  Yes  No  Unsure

Age of menarche: \_\_\_\_\_

Age of menopause (if applicable): \_\_\_\_\_

The above information provided is true to the best of my knowledge.

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Name

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Signature

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Date