Acupuncture Intake Form

Personal Information

Last Name:_____ First Name:_____

Date:_____ Birth Date:____/____/____ Gender:_____

Address:_____

City:_____ Province:_____ Zip: _____

Home Phone:_____ Mobile:_____

Address:_____

Occupation: _____

Referral Source: _____

Healthcare insurance (Manulife, Blue Cross, etc.) _____

Emergency Contact: _____ Phone:_____

Main Complaint

Please identify your major health concerns

1. _____

2. _____

3. _____

Personal Medical History *(Please include your childhood history)*

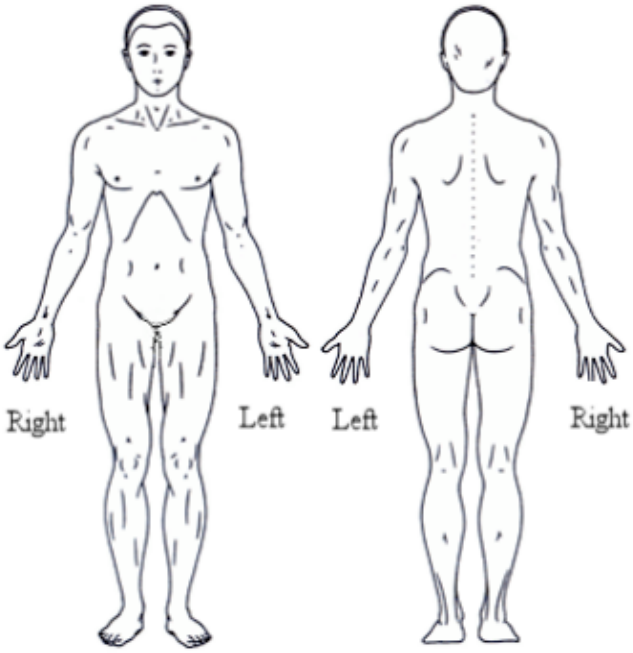
Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

<u>Pain:</u>

Using the symbols below, please mark on the body diagram if you have the following:

X = Pain
O = Numbness
Z = Tingling
/ = Other_____

On a scale of 1 - 10, how severe is your pain right now? _____



Patient Informed Consent to Treatment

I, _____, have discussed with my Traditional Chinese Medicine Practitioner or Acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, gua sha, and tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, if I am pregnant, if I am taking anticoagulants, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. In some cases my symptoms may temporarily worsen before they begin to improve.
6. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.
7. I have consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought.
8. I given permission for this office to bill my insurance company and provide audit information as required.

_____

Patient Name (Print)

_____ _____

Patient or Legal Guardian (Signature) Date