CONSENT TO TREATMENT

I, _____ hereby consent to acupuncture treatment for the relief of presenting symptoms. I understand that acupuncture is a generally safe, natural method of healing and I recognize the potential risks and benefits of these procedures as described below.

POTENTIAL RISKS: Our clinic uses only single use, disposable needles and maintains a clean and safe environment. Although uncommon, there is a potential for acupuncture to cause temporary bruising or bleeding, swelling, numbness, tingling, and soreness at the needle site that may last a short time. Rare side effects can include dizziness, light-headedness, or possibly the aggravation of pre-existing symptoms. If there is a significant worsening of symptoms please consult your physician.

HEALTH ALERTS: Acupuncture can be very beneficial in the treatment of symptoms during pregnancy; however, some acupuncture points are contraindicated during pregnancy. Other health conditions have a bearing on treatment given including heart conditions, diabetes or if you suffer some specific infections and illnesses. Please notify your acupuncturist if you become pregnant (or are trying to get pregnant) or suffer any relevant health conditions.

RESPONSIBILITY: Acupuncture is a complementary health service to your own primary health care; it is not a substitute for it. For emergencies and serious health concerns, please visit your primary care provider.

PRIVACY: It is very important that we work together to respect your privacy and the privacy of others. Let us know if there are certain topics that need extra discretion or if you prefer to do your intake in a more private setting. Health records are visible to clinic staff but are confidential. No information will be released or shared without your consent.

I have read, or have had read to me, the above. I have also had an opportunity to ask questions about its content, and consent to treatment. I intend this consent to cover the entire course of treatment for my present condition as well as any future conditions for which I seek treatment.

_____ _____

Signature of patient, or guardian Date

_____ _____

Signature of practitioner Date

Name: _____
File #: _____

CONFIDENTIAL PATIENT INFORMATION

Traditional Chinese Medicine offers a unique perspective on the nature of illness and health that is different from the Western perspective. It holds the human body in great reverence, respecting and promoting its endless capacity for rejuvenation and recovery.

Symptoms are the body's language. Through the differentiation of the symptoms you indicate on this form we will analyze the root cause of your condition. By harmonizing the body, mind and spirit, we can combat or prevent illness to improve the quality and duration of life.

Initial Acupuncture Visit $ 60 plus GST
Subsequent Acupuncture Visits $60 each plus GST.

Your Medical History		Family Medical History		Habits	
☐ Cancer	☐ High Blood Pressure	☐ Cancer	☐ Alcoholism	☐ Drugs	☐ Alcohol
☐ Hepatitis	☐ Heart Disease	☐ Diabetes	☐ Strokes/Seizure	☐ Coffee	☐ Cola
☐ Thyroid Disease	☐ Diabetes	☐ Asthma	☐ Allergies	☐ Salt	☐ Tea
☐ Rheumatic Fever	☐ Allergies	☐ High Blood Pressure	☐ Heart Disease	☐ Sugar	
☐ Other _____		☐ Other _____		☐ Other _____	

CHIEF COMPLAINT_____ HOW LONG?_____
WESTERN MEDICAL DIAGNOSIS_____

General			
☐ Fever	☐ Waking Up Too Easily	☐ Heavy Appetite	☐ Sweat Easily
☐ Chills	☐ Sudden Energy Drop	☐ Thirsty	☐ Peculiar Taste/Smell
☐ Night Sweats	☐ Fatigue	☐ Tremors	☐ Allergies
☐ Difficulty Falling Asleep	☐ Poor Appetite	☐ Bleeds/Bruise Easy	
Skin and Hair			
☐ Rashes	☐ Ulcerations	☐ Eczema	☐ Hives
☐ Hair Loss	☐ Itching	☐ Psoriasis	☐ Acne
☐ Other_____			
Head, Eyes, Ears, Nose and Throat			
☐ Dizziness getting up	☐ Migraines	☐ Dry Mouth/Throat	☐ Sinus Problems
☐ Dizzy Laying Down	☐ Gum Problems	☐ Nose Bleeds	☐ Poor Hearing
☐ Night Blindness	☐ Earaches	☐ See Spots	☐ Recurrent Sore Throat
☐ Blurry Vision	☐ Sore Eyes	☐ Grinding Teeth	☐ Sores On Lips/Tongue
☐ Headaches	☐ Ringing in the Ears	☐ Excess Saliva	☐ Mucus

Cardiovascular and Respiratory			
☐Chest Pain	☐Difficulty Breathing	☐Fainting	☐Swelling in Hand
☐High Blood Pressure	☐Bronchitis	☐Phlebitis	☐Swelling in Feet
☐Low Blood Pressure	☐Cough	☐Varicose Veins	☐Cold Hands/Feet
☐Irregular Heartbeat	☐Asthma	☐Blood Clots	☐Other _____
Gastro-Intestinal			
☐Belching	☐Odor-VeryStrong	☐Hemorrhoids	☐Nausea
☐Constipation	☐Bloody Stools	☐Rectal Pain	☐Bad Breath
☐Diarrhea	☐Black Stools	☐Pain or cramps	☐Vomiting
☐Alternating Diarrhea & Constipation		☐Rectal Prolapse	☐Gas
☐Bowel Movements _____X day		☐Laxative Use_____	
Genito-Urinary			
☐Frequent Urination	☐Wake up to urinate	☐Blood in Urine	☐Impotency
☐Urgency to Urinate	☐Painful Urination	☐Unable to Hold Urine	☐Kidney Stone
Gynaecology & Pregnancy			
☐Period (reg. 28 days)	☐Painful Periods	Last Period _____	Pregnant☐ Yes ☐No
☐Irregular Periods	☐Mood Changes	☐Vaginal Discharge	☐Miscarriages
☐Menstrual Clots	Period Duration _____	☐Spotting	☐Premature Births __
☐Breast Swelling/Lump		# of Pregnancies _____ births _____	
☐Menopause (what age?) _____		☐Other	
Color ☐Dark ☐ Light	☐Birth Control	Flow ☐Heavy ☐Medium ☐Light	
Musculo-Skeletal			
☐Joint Pain	☐Muscle Pains	☐Neck Pain	☐Back Pain
☐Bone Pain	☐Other _____		
Neurophysiological			
☐Anxiety	☐Poor Memory	☐Depression	☐Areas of Numbness
☐Easily Stressed	☐Bad Temper	☐Treated for Emotional Problems	
☐Considered/Attempted Suicide		☐Other _____	

Pulse (For Office Use Only)

Speed: _____
Strength: Xu SHI Norm
Width: Thready Wiry Norm

Length: Short Long Norm
Rhythm Knotted Inter Hurried Norm
Slippery Choppy Sticky Tight Normal

Left			Position	Right		
Front	Mid	Rear		Front	Mid	Rear
•	•	•	Superficial	•	•	•
•	•	•	Middle	•	•	•
•	•	•	Deep	•	•	•

Tongue:
Body _____
Coat _____
Geography _____