

PATIENT INTRODUCTION FORM

LAST name: _____ Marital Status S M W D
 Address: _____ First _____ Initial _____
 City: _____ Postal Code: _____ Number of children: _____
 Telephone: H _____ W _____ C _____ Email _____
 Sex: Male Female Date of Birth: M _____ D _____ Y _____ Age: _____
 Family Physician: _____ Physician telephone number: _____
 Occupation: _____ Referred by: _____

Which Insurance Company _____ Any private insurance:

Do you have reason to believe that you may be pregnant? No Yes Due date: _____

REASON FOR VISIT: _____

If you are experiencing pain, is it: Shooting Sharp Stabbing Throbbing Achy Burning Dull (Please circle)

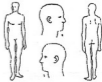
ARE YOU EXPERIENCING NUMBNESS OR TINGLING? Yes No

How would you classify your pain level? Slight Moderate Severe (Please circle)

When did it start: _____

What relieves the condition: _____

What aggravates the condition: _____



Is the condition getting worse? Yes No Constant Comes and goes (Please circle) mark area

Have you seen a: Chiropractor Physiotherapist Massage therapist Acupuncturist Physician Other (Please circle)

For what condition and when: _____

Have you had any surgery? Yes No For what part and when? _____

Are you presently taking medication? Yes No If yes, please give name and what it's for: _____

In consideration of your practitioner and fellow patients, **24 hour notice of change of appointment or cancellation must be given or a fee will be charged.** Patient is responsible for payment of services if medical insurance is not valid. _____ Initial please.

Signature: _____ Date: _____

Please indicate conditions presently causing problems as well as conditions which were a problem in the past.

BABIES & CHILDREN

	Present	Past
Birth trauma	<input type="checkbox"/>	<input type="checkbox"/>
Feeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delays	<input type="checkbox"/>	<input type="checkbox"/>
Behavioural	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity / ADD/ ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Eye motor problems	<input type="checkbox"/>	<input type="checkbox"/>
PDD/autism	<input type="checkbox"/>	<input type="checkbox"/>

HEAD/NECK/BACK

	Present	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Dental Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Problems		
pain/clicking/locking	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>
List _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

	Present	Past
Chronic Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>

OTHER CONDITIONS

HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		
Onset Date: _____		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Susceptible to colds / infections	<input type="checkbox"/>	<input type="checkbox"/>
High Stress Levels	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia / Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness and/or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Infectious conditions	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>
STD's	<input type="checkbox"/>	<input type="checkbox"/>
Tumors / Cysts	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
IUD	<input type="checkbox"/>	<input type="checkbox"/>
Gynecological concerns (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

	Present	Past
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker / other device	<input type="checkbox"/>	<input type="checkbox"/>
Coldness in extremities	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

	Present	Past
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Pain or discomfort before eating	<input type="checkbox"/>	<input type="checkbox"/>
Pain or discomfort after eating	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder (anorexia/bulimia)	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT CONSENT FORM

Please read this information carefully and ask your practitioner if there is anything that you do not understand.

Chinese medicine and its related treatments like acupuncture have proven to be highly effective in correcting and maintaining overall well-being. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects may occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness may occur in a small number of patients, and if affected, you are advised not to drive.
- Minor bleeding may occur.
- Bruising may occur.
- In some cases (less than 5%) symptoms may become worse (before they improve) for 1-2 days following treatment. This is often a good sign. Please advise your practitioner if worsening of symptoms continues for more than 2 days.
- Fainting may occur in certain patients, particularly at the first treatment.

What are the possible side effects from Chinese medicine and other treatments?

- Bruising is a common side effect of cupping.
- All herbs/medicinal substances that will be prescribed are traditionally considered safe in the practice of Chinese medicine and have been approved for use by the Canadian Health Authority.

Is there anything your practitioner needs to know?

It is important to let your practitioner know if you:

- have ever experienced a fit, faint, or other odd detached sensations.
- have a pacemaker or any other electrical implants.
- are pregnant.
- have a bleeding disorder.
- are taking anti-coagulants (blood thinners) or any other medication.
- have damaged heart valves or have any other particular risk of infection.

What are some policies that may concern you?

- **Extended Treatment Policy:** If a session exceeds the regular duration, an additional fee will be charged.
- **Sales Policy:** All sales are final and non-refundable.
- **Appointment Cancellation Policy:** A 24-hour notice of change of appointment or cancellation must be given or a fee will be charged.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatment and procedures. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based on the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic and have had an opportunity to ask questions I have also read the policies discussed above, and I consent to following them. I intend this consent form to cover the entire course of treatment for my present condition, and further conditions for which I seek treatment.

Print name in full

Signature

Date

Informed Consent for Acupuncture Treatment

I, or the person listed below, 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 massage. 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 my major health issues, if I suffer from any type of major bleeding disorder, or if 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 are not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases, my symptoms may temporarily worsen before they begin to improve.
6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.
7. 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.

Print Name of Patient

Signature of Patient

Witnessed

Date: _____