ACUPUNCTURE
PATIENT HISTORY

Patient Information

Patient's Legal Name: ____ Preferred Name____________ Date: __________________

Address: ____________________________________ City: _______________________ Postal Code: _____________________

Home #: _____________________ Work #: _______________________ Cell #: ____________________________

Cell Provider (optional): ___________________ Email (optional): ____________________________________ *Your cell and email will not be shared with third parties & is used for appointment reminders. I understand that I can opt out at any time by informing CARE that I no longer wish to receive appointment reminders.*

Birth Date: D/ ___ M/ ____ Y/ ________ Age: ____ ☐ M ☐ F Married _____ Single ______

Occupation: ________________________________

AHC #: ___________________ Medical Doctor: ________________________ Phone #: ______________

In case of emergency, contact: ____ Phone: ______________________

Whom may we thank for referring you to our office? ____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis/varicose veins
- ❑ Stroke/CVA
- ❑ Pacemaker or similar device
- ❑ Heart disease
- ❑ Dizziness/vertigo
- ❑ Seizures

Is there any family history of any of the above? ❑ Yes ❑ No

____

Head and Neck
- ❑ History of headaches
- ❑ History of migraines
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss

Women
- ❑ Pregnant
  Due date: _______________________
- ❑ Previous pregnancy complications:
  ____
- ❑ Menopausal complications:
  ____
- ❑ Menstrual complications:
  ____
- ❑ Gynecological Conditions:
  ____

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic cough
- ❑ Shortness of breath

Is there any family history of any of the above? ❑ Yes ❑ No

Skin Conditions
- ❑ Open sores
- ❑ Eczema
- ❑ Psoriasis
- ❑ Rash
- ❑ Warts

Muscle/Joint
- ❑ Neck
- ❑ Back (Lower)
- ❑ Back (Mid)
- ❑ Back (Upper)
- ❑ Shoulders
- ❑ Elbow
- ❑ Wrist/Hand
- ❑ Hip
- ❑ Knee
- ❑ Ankle/Foot
  M-1
- ❑ Spine

Men
- ❑ Enlarged prostate
- ❑ Libido issues
- ❑ Other: __________________________

Digestive
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Irritable Bowel Syndrome
- ❑ Ulcers

Infectious Conditions
- ❑ Skin Conditions
  ____
- ❑ Respiratory conditions
  ____
- ❑ Hepatitis

Other
- ❑ Loss of sensation
  Where: ______________________
- ❑ Diabetes
  Onset: ______________________
  Type: _______________________
- ❑ Allergies/Hypersensitivity
  What? ______________________
- ❑ Epilepsy
- ❑ Cancer
  Type: _______________________
  Location: ____________________
- ❑ Arthritis
  Is there a family history of arthritis? ❑ Yes ❑ No
- ❑ Hemophilia
- ❑ Fibromyalgia
- ❑ Chronic fatigue
- ❑ Scoliosis
- ❑ Polio/Post-polio
- ❑ Osteoporosis

Relevant History

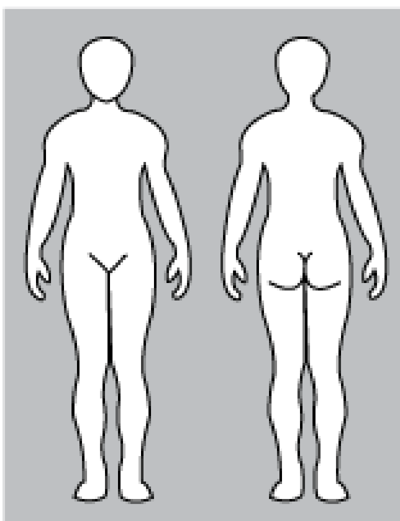
2. Do you have any medical conditions not listed above? ❑ Yes ❑ No
   If yes, please describe: ____
____
____

3. Do you have any internal wires, artificial joints, pacemakers or special equipment? ❑ Yes ❑ No
4. For what condition or reason are you seeking treatment today? ____
____
____

5. Have you seen any other health care professional(s) for this condition or reason? ❑ Yes ________________ ❑ No
6. Have you ever been involved in any motor vehicle accidents? ❑ Yes ❑ No Date: __________________________
7. Have you ever been involved in any other accidents? ❑ Yes ❑ No Date: __________________________
8. Have you ever been knocked unconscious? ❑ Yes ❑ No Date: __________________________
9. Briefly list any surgeries you have undergone, for what & when____

10. Are you presently taking any prescribed medication(s)? ❑ Yes ❑ No If yes, please describe: ____________________
____
____
____

11. Please mark the areas which are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort:



______________________________ ______________________________

Signature Date

Notes:

Consent to Treat

I, _______________________________ hereby agree and consent to the performance of acupuncture and other Traditional Chinese Medicine modalities performed by a Registered Acupuncturist in the province of Alberta. I understand that such procedures may include, but are not limited to:

- **Acupuncture**: disposable stainless steel needles inserted at specific points in the body to treat various ailments.
- **Cupping**: suction cups are applied to specific points on the body
- **Electro-acupuncture**: acupucture needles are electrically stimulated at various high frequencies to cause relaxation of the muscles and analgesia of the area of pain involved
- **Moxibustion**: Herbal heat is applied to specific acupuncture points
- **Gua Sha**: superficial dermal friction is applied to theskin
- **Exercise** and/or **nutritional counselling** based on TCM theories
- **Herbal Medicine counselling**

I understand that while generally painless there are possible side effects from the above mentioned treatments such as: bruising, numbness or tingling, dizziness or fainting, weakness, tiredness, nausea, minor swelling, bleeding, temporary pain or discomfort, hematoma at puncture site or blistering at Moxabustion site. A sensation of light-headedness may occur after acupuncture treatment and/or temporary aggravation of existing symptoms.

By voluntarily signing below I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions with regards to the modalities described above. Additionally, I have consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought.

I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

<u>Consent to the Collection, Use and Disclosure of Personal Health Information:</u> Maintaining the protection of personal health information is required by provincial and federal law. This information will be securely maintained in charts or electronically for a minimum of ten years past the last date of treatment. To access this information, the Clinic must receive my written consent to release this information to a designated individual or organization. I understand that this information will be accessible to and shared amongst each of the health service providers within the clinic for the purposes of providing integrated, patient centered health services for Chiropractic/Acupuncture/Massage Therapy services and to obtain payment from a third party insurance company for treatments provided.
I understand that I am able to withdraw my consent by providing written notice to the treating practitioner.

_______________________________ _______________________________

Signature Date