PATIENT INTRODUCTION FORM

LAST name:____ First ______________ Initial ______________ Marital Status S M W D

Address: ____ Spouse's name: ____________

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: ____________________________

B.C. CARECARD #: ____ Any private Insurance: Y☐ N☐

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

Is this a claim from: ICBC ______ WCB_______ Claim #: ____________ Date of Accident ______________________

End date of claim: ______________ Adjuster's name: __________________ Telephone #: __________________

REASON FOR VISIT: ____

____

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

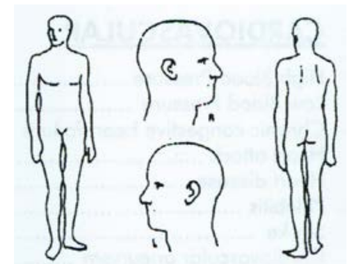
ARE YOU EXPERIENCING NUMBNESS OR TINGLING? Yes☐ No☐

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	☐	☐
Feeding problems	☐	☐
Colic	☐	☐
Recurrent ear infections	☐	☐
Developmental delays	☐	☐
Behavioural	☐	☐
Hyperactivity / ADD/ ADHD	☐	☐
Learning disabilities	☐	☐
Eye motor problems	☐	☐
PDD/autism	☐	☐

RESPIRATORY	Present	Past
Chronic Conditions	☐	☐
Shortness of Breath	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Allergies	☐	☐

CARDIOVASCULAR	Present	Past
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Chronic congestive heart failure	☐	☐
Heart attack	☐	☐
Heart disease	☐	☐
Phlebitis	☐	☐
Stroke	☐	☐
Cardiovascular aneurysm	☐	☐
Pacemaker / other device	☐	☐
Coldness in extremities	☐	☐
Varicose Veins	☐	☐
Arteriosclerosis	☐	☐
Poor Circulation	☐	☐

GASTROINTESTINAL	Present	Past
Heartburn	☐	☐
Pain or discomfort before eating	☐	☐
Pain or discomfort after eating	☐	☐
Nausea	☐	☐
Gas	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Diarrhea	☐	☐
Ulcer	☐	☐
Digestive Problems	☐	☐
Eating Disorder (anorexia/bulimia)	☐	☐

HEAD/NECK/BACK	Present	Past
Headaches	☐	☐
Migraines	☐	☐
Dental Surgery	☐	☐
Orthodontics	☐	☐
Jaw Problems		
pain/clicking/locking	☐	☐
Whiplash	☐	☐
Vision Problems	☐	☐
Contact Lenses	☐	☐
Ear Problems	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Ringing in ears	☐	☐
Sinus Problems	☐	☐
Facial Pain	☐	☐
Head Injury	☐	☐
Spinal Injury	☐	☐
Other neurological conditions	☐	☐
List____________________	☐	☐
____________________	☐	☐

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

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