Back to Health
CHIROPRACTIC AND WELLNESS

PATIENT INFORMATION

Full Name: _____ Date of Birth (mm/dd/yy):_____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (home)_____ (work) _____ (cell) _____

Occupation: _____ Marital Status: _____ Sex: _____

Emergency Contact: _____ Phone Number: _____

E-mail:_____

How did you hear about us? _____

FAMILY PHYSICIAN

Name of Family Physician: _____ Phone: _____

Medical Centre/Office Location: _____

Date of last visit: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____ Cell: _____

PRIMARY HEALTH CONCERNS

Please list your primary health concerns/chief complaints:

_____

_____

_____

Of which of these concerns is the most important to you? _____

MEDICAL HISTORY AND INFORMATION

Heart disease _____Y/N HBP _____Y/N High Cholesterol _____Y/N Pacemaker _____Y/N
Blood Thinners _____Y/N Seizures _____Y/N Electrical Implants ____ Y/N Pins _____Y/N

Allergies
Please list any allergies you may have: _____

Medications
Please list all medications you are currently taking including vitamins, herbal and illicit:
_____

_____

Please list how often you smoke and/or use alcohol:
_____

Hospitalizations/Surgeries
Please list to the best of your ability the times you have been hospitalized and illness/procedure:
_____

_____

_____

WOMEN:

Pregnant now: YES NO UNKNOWN

Indicate number of Occurrences:
Live Births _____ Pregnancies _____ Miscarriages _____ Abortions _____

Menstrual Cycle:

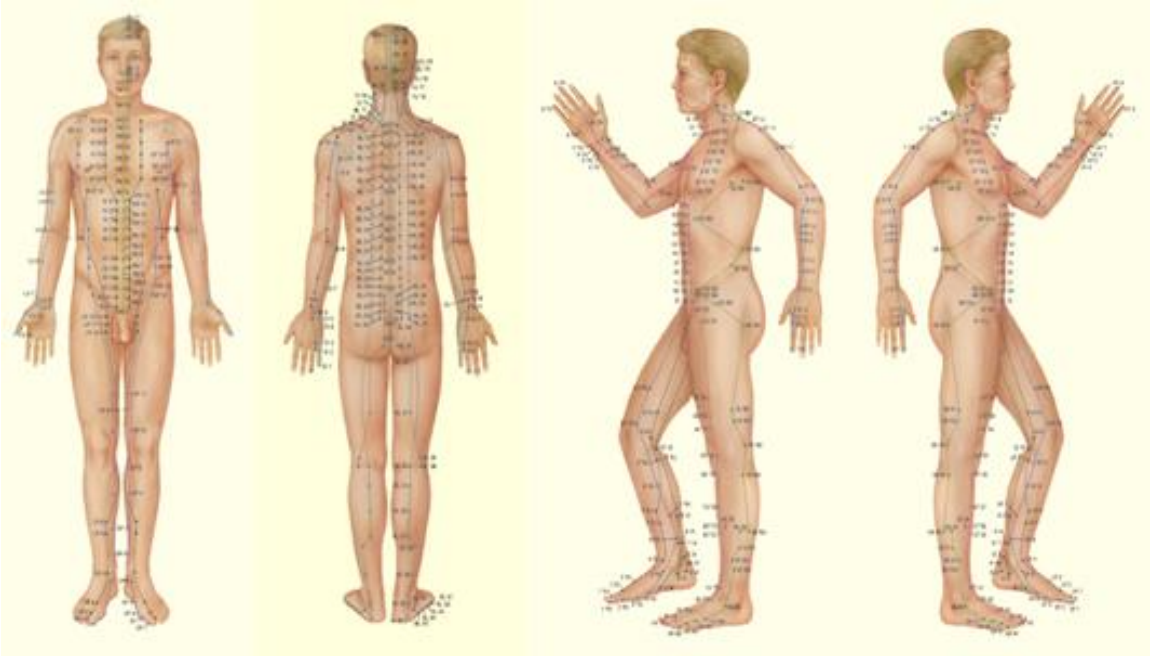
Frequency: _____ Flow (Normal/Heavy/Light) _____ Clotting _____

Age of Menopause _____ (if applicable)

Blood Borne, Insect Borne and Sexually Transmitted Diseases
Due to the use of needles below the skin, please check if you are experiencing any of the following. *Any misinformation can result in termination of treatment, among legal complications.*

☐ HIV/Aids
☐ Hepatitis B
☐ Hepatitis C
☐ Chlamydia
☐ Encephalitis
☐ Genital Warts
☐ Gonorrhea
☐ Herpes
☐ Malaria
☐ Pelvic Inflammatory Disease
☐ Syphilis
☐ Trichomonas
☐ Tuberculosis
☐ Other: _____

Please mark any areas where you experience pain on the figures below with an X:



How would you describe the pain? (please circle all that apply):

dull/achy	sharp/stabbing	tingling
pins&needles	electric	numbness
burning	fixed in one spot	moving around

Please circle all that pertain to you:

Qi
general tiredness
lack of morning energy
weakness of limbs
spontaneous sweating
poor appetite
hunger w/o desire to eat
loose stools
dislike of speaking
discomfort in abdomen
chest distension
depression
frequent sighing
feeling of lump in throat
inability to digest fats

Blood
dizziness
palpitations
dull complexion
numbness and tingling
weak muscles
muscle cramps
poor memory
blurry vision
floaters in vision
dry eyes
pale lips
white nails
difficulty staying asleep

Body Fluids
dry Mouth, nose, lips, eyes
cracked lips
dry cough
dry Skin
hoarse voice
lack of sweating
scanty urination

Elimination
dark urine
scanty urine
blood in stool
blood in urine
abundant clear urine

Lung (LI/Metal)
shortness of breath
asthma
cough
sinus problems
environmental allergies
no sense of smell
skin problems
fear
expectoration of phlegm
rattling sound with voice
nose bleeds

Liver (GB/Wood)
distention in the ribs
irritability
outbursts of anger
breast distention
sour regurgitation
hiccups/belching
mouth ulcers
eye problems
gallstones
headaches
stress
timidity
anxiety
craving sour food
dream disturbed sleep
ringing in ears (high pitch)

Stomach (SP/Earth)
excessive thirst
lack of thirst
sticky taste
bleeding gums
foul breath
excessive hunger
borborygmous (stomach growling)
burning sensation in stomach
loose stool
vomiting
heartburn
nausea
prolapse
racing thoughts
craving sweet food
edema
difficulty getting to sleep
mental restlessness
food allergies
over-thinking
odorous sweat

Yin/Yang
hot body temperature
cold body temperature
preference for hot drinks
preference for cold drinks

Heart (SI/Fire)
palpitations
high blood pressure
low blood pressure
easily startled
shortness of breath on exertion
Pale complexion
tongue ulcers
stuffiness in the chest
cold hands
stabbing chest pain
sadness
craving spicy food

Kidney (UB/Water)
low back pain
knee problems
weak or cold legs
decreased libido
impotence
infertility
night sweating
tinnitus (low pitch)
metallic taste in mouth
deafness
hot flashes
feelings of heat in palms or feet
depression
lack of initiative
craving salty food
waking to urinate
dark urine
scanty urine
blood in stool
blood in urine
abundant clear urine
dribbling after urination

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Traditional Chinese Medicine. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, guasha, herbal therapy, tuina (chinese massage).

I am hereby informed that the aforementioned treatment methods are all generally safe but there may be some side effects or risks, as follows:

1. Acupuncture may potentially cause temporary bruising, swelling, bleeding, tingling or soreness at the sight of needling. Unlikely, risks of acupuncture, include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although, only sterile, disposable needles are used within a clean safe environment.

2. Potential risks of moxibustion, cupping and guasha are temporary bruising, blisters and redness lasting a few days.

3. The herbal and nutritional supplements are generally safe in the traditionally recommended doses. The herbs/nutritional supplements are for *you* and not for anyone else. Possible side effects of herbs include, nausea, flatulence, stomachache, headache, and skin eruptions. If I experience any of the above symptoms I must stop taking the herbs and notify your practitioner.

4. I will notify the practitioner should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

5. I understand that I can discuss the risks and benefits further before signing, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise her judgement in my best interest during the course of treatment, based upon the facts known.

6. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment.

7. After receiving acupuncture treatment you might feel a little lightheaded (and sometimes euphoric). Please feel free to have a seat, drink a little water and relax to let yourself come back to normal.

8. All fees are payable at the time of your treatment.

9. If you must miss an appointment, please let this office know at least 24 hours prior to your scheduled appointment. Failure to do so may result in a missed appointment fee equal to the cost of the appointment.

10. I give consent to allow my file to be shared with all practitioners within the Back to Health clinic if necessary.

_____

Patient Name Patient Signature Date

_____

Witness Name Witness Signature Date