New Patient Intake Form

Today's Date _____ / _____ / _____
Month Day Year

Name _____ Date of Birth _____ / _____ / _____
Month Day Year

Marital Status _____ Age _____

Address _____ Sex ☐ M ☐ F Height _____ Weight _____

City, Province, Postal Code _____ Occupation _____

Home Ph.# _____ Work Ph.# _____ Cell Ph# _____

Emergency contact name & ph. # _____ E-mail _____

Referred by _____ Have you ever had acupuncture? ☐Yes ☐No

How did you hear about the clinic? _____ Have you ever had Chinese herbal medicine? ☐Yes ☐No

Reason for visit today _____

Primary health concerns & complaints _____

How long have you had this condition? _____ Is it getting worse? _____

Does it bother your: ☐Sleep ☐Work ☐Other (what?) _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under the care of a physician now? ☐Yes ☐No If yes, for what? _____

Who is your physician? _____ Physician's Ph. # _____

Is this condition related to an accident or injury at work? ☐ Yes ☐No

If yes, please provide WCB claim # _____ Case manager's name & ph. # _____

Other concurrent therapies _____

Do you have any contagious diseases at this time? (Hepatitis, H.I.V., T.B., Influenza etc.) ☐Yes ☐No
If yes, please list: _____

Show area(s) of pain or unusual feeling.

Mark the areas on the body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

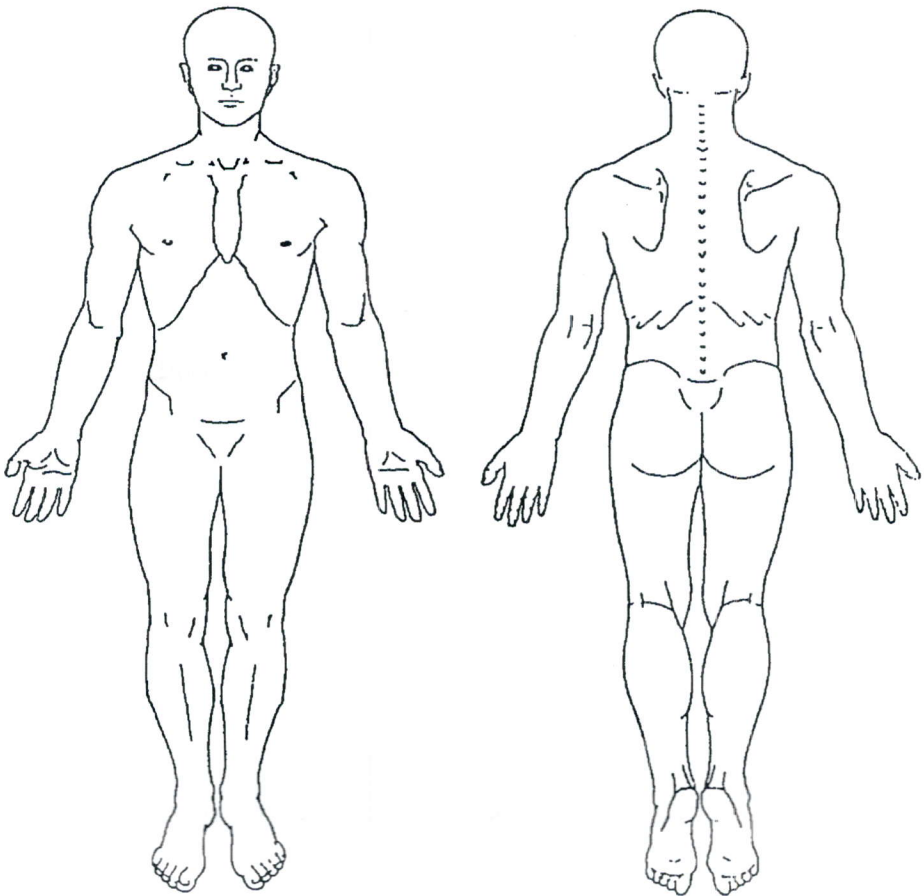
Numbness ●●●●
●●●●
●●●●

Pins & Needles OOOO
OOOO
OOOO

Burning XXXX
XXXX
XXXX

Aching A A A A
A A A A
A A A A

Stabbing / / / /
/ / / /
/ / / /



Informed Consent

PLEASE READ CAREFULLY

Informed Consent for Acupuncture Care

I, _____ do hereby voluntarily request and consent to be treated with Acupuncture and other procedures related to Acupuncture including needling, moxibustion, cupping, gua sha, laser, electroacupuncture or any other techniques within the scope of practice of acupuncturists. These procedures may be performed by the registered Acupuncturist named above.

I have had the opportunity to discuss with the registered Acupuncturist the nature and purpose of Acupuncture care and other procedures. I understand that Acupuncture has been safely practiced for centuries. I also understand that no guarantees concerning its use and effects are given to me, and that I am free to discontinue Acupuncture treatment at any time.

I further understand and am informed that, as in all health care, in the practice of Acupuncture, even though all needles are pre-sterilized and disposable, there are some risks to treatment including but not limited to temporary soreness or discomfort, bruising, blistering, nausea, fainting, bleeding, infection, shock, and possible temporary aggravation of symptoms. I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedures that he feels are in my best interest. I consent to having blood tested in case of needlestick accident at any time during my course of treatment in clinic.

I have read the above consent. I understand all of the foregoing, and by signing below I agree to the above procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient, Parent or Guardian **Signature**

_____

Date