THRIVE
Chiropractic & Wellness Centre

Acupuncture Intake

Date: _____/_____/_____ (MM/DD/YY)
First Name: _____ Last Name:_____
DOB: _____/_____/_____ (MM/DD/YY) E-mail: _____
Preferred Phone #: _____ Other Phone: _____
Address: _____ Guardian: _____
_____
_____
Family Doctor: _____
Name of Referring Professional: _____
Emergency Contact: _____
(emergency contact phone #):_____
How did you hear about us?: _____
What is the reason for your visit?
_____ Pain management/Sports injury _____ General Wellness _____ Fertility

Do you have any of the following conditions?

____ High Blood Pressure
____ Fainting Spells
____ Hepatitis B or C
____ Pace Maker
____ Bleeding Disorder
____ Epilepsy
____ HIV/AIDS
____ None of the above

Please list all of your current medication and/or supplements:
_____
_____
_____

Please list any allergies to medication/food/environment:
_____
_____
_____

If you have recently had surgery, been in an accident or been diagnosed with a serious illness, please list the details below:
_____
_____
_____

Consent Form

Potential risks of acupuncture can include bruising, slight discomfort at the sight of needle insertion, infection, weakness, numbness, nausea, fainting, and possible aggravation of problematic systems existing prior to acupuncture. Unusual risks include nerve damage or organ puncture.

Cupping and guasha therapy can result in the discolouration of the skin (called petechiae) and resolves in about 3-5 days.

Herbal medicine is a supplemental plant/animal mineral source that is traditionally considered safe in the practice of Oriental medicine. Rare side effects of herbal medicine include digestive upset, nausea, headache, rash, hives, spontaneous miscarriage, and tingling of the tongue.

By signing this, I _____, certify that the
(PLEASE PRINT)
above medical information is correct to my knowledge. I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring health care professional as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I understand the risks associated with acupuncture, cupping, guasha, and herbal medicine. I have been given the opportunity to ask questions and/or voice concerns before my treatment protocol begins.

_____
(PATIENT SIGNATURE)

_____
(DATE)

_____
(PRACTITIONER SIGNATURE)

_____
(DATE)

We understand circumstances arise, however, please note a fee of 50% of the scheduled acupuncture fee will be applied for multiple missed or cancelled appointments without 24 hours notice.

_____
Initial