OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

Acupuncture & Chinese Medicine Health Form

PERSONAL INFORMATION

Name: _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell #: _____ Office #: _____

Email: _____

☐ Yes ☐ No I consent to receiving email communication from Oaktree
(Emails we will send you will include news updates from Oaktree. We will not spam you and you can unsubscribe at anytime. You will still receive appointment reminders and other important notices via email.)

Birth date: [M]_____ [D]_____ [Y]_____ Age: _____ Weight: _____ Height: _____

Workplace: _____ Occupation: _____

Referred by: _____

Marital Status: ☐ Single ☐ Common law ☐ Married (spouse name: _____)
☐ Divorced ☐ Separated ☐ Widowed

Do you have extended health care benefits that contribute to acupuncture care?
☐ Yes ☐ No Amount per year: _____

ACUPUNCTURE HISTORY

Have you ever been to a acupuncturist before? ☐ Yes ☐ No

Name of Acupuncturist: _____ City: _____

Date of last visit: [M] _____ [Y] _____ Duration & Frequency of Care: _____

MAJOR COMPLAINTS

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

MEDICAL HISTORY

SUPPLEMENTS

Do you take any supplements? ☐ Yes ☐ No Which:

☐ Omega3 ☐ B vitamin ☐ Probiotics

☐ Vitamin D ☐ Multivitamin ☐ Iron

☐ Other: _____

MEDICATIONS

Name and for which condition(s)?

_____

_____

_____

_____

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

_____

_____

_____

_____

SURGERIES

For what condition(s)? (include year preformed)

_____

_____

_____

_____

OTHER HEALTH PROBLEMS, CONCERNS OR ADDITIONAL INFORMATION

_____

_____

_____

INFORMED CONSENT FOR ACUPUNCTURE EXAM AND TREATMENT

I understand that Acupuncture and other Traditional Chinese Medicine modalities are safe when used for both prevention and treatment of a wide range of health problems, as well as for the promotion of general well-being. I understand that acupuncture is not a substitute for conventional medical diagnosis and treatment provided by a medical doctor. I am aware that the acupuncturist does not diagnose illnesses or diseases and does not prescribe medications.

I have informed the acupuncturist of all my known physical and emotional conditions, medical conditions and medications, and I will keep the acupuncturist updated on any changes. If I experience any pain or discomfort during the session, I will immediately communicate that to the acupuncturist so the treatment can be modified. I understand that occasional bruising and post-needling sensation may happen, as well as mild side effects such as fatigue and pain. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information. I realize no claims, promises or guarantees are being made, and I accept full responsibility for the risk. I recognize that social habits may decrease the beneficial effects of acupuncture and Chinese herbs.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of present and future care.

I understand that the purpose of today's visit is to determine if I am a candidate for Traditional Chinese Medicine & Acupuncture care and that I am responsible for any fees agreed upon between myself and the practitioner. All examination fees will be explained to me before any tests are performed.

TO BE COMPLETED BY PATIENT:

_____ _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) *PRINT PATIENT'S NAME*

_____ _____

DATE SIGNED *WITNESS*