healthworks
chiropractic & wellness centre

ACUPUNCTURE
Traditional Chinese Medicine

Please Read Carefully

An accurate health history is important to ensure that it is safe for you to receive acupuncture. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential. This record will not be released to others without your consent, unless required by law.

Name: ____

Address: ____

City: ______________________________ Province: _____________________ Postal Code: _____________

Email: ____

Home Phone Number: _____________________________ Cell Phone Number: _________________________

Work Phone Number : _____________________________ Cell Phone Provider: _________________________

Date of Birth: _______/________/__________ Age: _____________
MM DD Y Y Y Y

How would you prefer us to remind you of appointments?

Email ☐ *Text Message* ☐ *Home Phone* ☐

Emergency Contact: ______________________________ Relationship: _______________________________

Telephone Number: ______________________________ Cell Phone Number: __________________________

Physician's Name: _______________________________ Physician Phone Number: ____________________

Did a health care practitioner refer you to acupuncture? Yes ____ No ______

Are you under the care of any other heath care practitioner? Yes ____________________________ No _____

Whom may we thank for referring you to this office? ____

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Traditional Chinese Medicine Acupuncture

CONSENT TO EXAM AND TREATMENT

Please take time to read this form, which will provide you with some basic knowledge about acupuncture.

Acupuncture is safe and effective for the prevention and treatment of a wide range of health problems, and for the promotion of general well being. Occasional bruising and post-needling sensation may occur. Fainting may occur for new patients due to nervousness, hunger or extreme fatigue. Occasional digestive upset, diarrhea, insomnia, fatigue, pain or sweating may occur as a response to treatment.

Acupuncture is NOT a substitute for conventional medical diagnosis and treatment provided by a medical doctor. Acupuncture does NOT diagnose illnesses or diseases and does NOT prescribe medications.

While receiving acupuncture treatment, please feel free to communicate what you are experiencing during the needling process, as this will enable me to adjust the needles and the points selected to maximize your comfort during the treatment. If you have any concerns please do not hesitate to ask.

Acupuncture is NOT covered by the Ontario Health Insurance. Coverage is provided by some extended healthcare plans, please check your policy. The cost for the initial assessment with treatment is $70.00. Each treatment thereafter is $55.00. I am offering a package of 10 treatments for $500.00, not including the initial assessment and treatment. Payments must be made at the time of treatment and no charges to your account will be accepted. A $20.00 NSF fee will be applied to any returned cheques. If you are unable to make your scheduled appointment, please call Health Works as soon as possible. Missed appointments without notification are subject to a fee of $10.00.

In recognition of the Privacy Act, all information collected is strictly confidential and only necessary information required for proper care within H.W.C.W.C. This record will not be released to others without your consent, unless required by law.

In the event of any unforeseen circumstances in which you are unable to complete your treatment plan, please notify the clinic immediately. Any outstanding fees will be due. A refund policy is in effect for any remaining amount. However, there are no refunds for prepaid treatments after one year from your previous visit.

I hereby request and consent to receive acupuncture, tuina massage and other related treatments and have read and understand the above policies and agree to abide by them.

____
Signature of Patient or Guardian

____
Print Patient’s Name

____
Signature of Practitioner

____
Dated

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NAME: ____

DATE OF BIRTH: ___________/________/__________ **SEX:** ______ **AGE:** _________________

day / month / year

HOME PHONE NUMBER: ________________________ **CELL PHONE NUMBER:** ____________________

Have you had Acupuncture therapy before? Yes / No

If so,

When: ____

Why? ____

Will you be claiming treatment through insurance? ____

Whom may I thank for referring you to this office? ____

What would you like to accomplish with Acupuncture? ____

Please indicate if any of the following pertain to you:

(Marking yes does not disqualify you from receiving treatment, however; it may restrict some of the treatments)

☐ Hepatitis ☐ Pacemaker ☐ High Blood Pressure ☐ HIV

☐ Seizures ☐ Blood Thinners ☐ Pregnancy

Current Medication and /or Supplements (include those taken in the last 6 months):

____

____

SPECIFIC CONCERNS:

	PRIMARY CONCERN	SECONDARY CONCERN
Specific concerns and location/cause		
How long have you had this? Time/Duration		
How often does this happen?	Constant On/Off Daily	Constant On/Off Daily

What makes it worse? (sitting, standing, etc.)		
What have you tried to address this concern? (Prior Treatment)		
What makes it better?		

General Information:

1. **Chills & Fever:** □ Chills □ Fever □ Chills & Fever □ Hot □ Cold □ Hotflash

2. **Sweat:** □ No Sweat □ Profuse Sweat □ Spontaneous Sweat □ Night Sweat
□ Sweats Easily Location of Sweat ______________________________

3. **Pain:** □ Head □ Neck/ Shoulder □ Upper Back □ Lower Back □ Joint □ Rib

Quality: □ Sharp □ Dull □ Distending □ Other ___________________________

Severity: □ Mild □ Moderate □ Excruciating

Frequency & Duration: □ Constant □ Intermittent □ Chronic □ Acute

Cause of Pain: ____

4. **Head & Body:**

Head: □ Dizziness □ Vertigo □ Headaches □ Migraines □ Concussions

Other Head or Neck Problems ____

Chest: □ Tightness □ Palpitations □ Asthma □ Cough □ Phlegm/ Colour

□ Difficulty Breathing □ High Blood Pressure □ Low Blood Pressure

Abdomen: □ Bloating □ Distension □ Nausea □ Gas □ Acid Regurgitation

Tingling & Numbness: □ Face □ Tongue □ Limbs □ Half side body □ Fingers □ Toes

5. **Ears:** □ Hearing Loss □ Ringing □ One Side □ Both Sides □ High/Low volume

□ Continuous □ Intermittent

Eyes: □ Clear □ Blurred □ Floaters □ Dry □ Itchy □ Tearing

□ Glaucoma □ Cataracts □ Night Blindness

Mouth: □ Grinding teeth □ TMJ □ Facial Pain □ Gum Problems □ Sores mouth/lip

□ Sore throat □ Swollen Glands □ Nose Bleeds

6. **Dietary:**

Thirst: □ # Glasses water/day _____ □ Cold □ Hot □ Desire to drink Y / N

Food: □ Loss of appetite □ Over Eating □ Hunger with no desire to eat

□ Abnormal taste in mouth

___# meals/ day ___ # snacks

□ Warm food □ Cold food □ Spicy food □ Sour food □ Sweet food

7. **Defecation & Urination:**

Stool: □ Frequency #___ /day □ Formed □ Loose □ Sticky □ Colour □ Odour

□ Constipation □ Burning Anus □ Hemorroid □ Diarrhea

Urine: □ Frequency #___ /day □ Colour □ Odour □ Frequent □ Urgent

□ Unable to hold □ Incomplete

8. **Sleep:** □ What time goes to bed:_______ □ How many hours sleep_____

□ Ease / Difficulty falling asleep

____ # of Times awaking □ Restless at night □ Dreams disturbed

□ Dreams not disturbed □ Wakes to urinate □ Wakes tired

□ Wakes with heaviness

□ Wakes with mental fatigue, poor memory

9. **Women's Conditions:**

Menstruation: □ Length of Cycle □ Days of Period □ Bleeding Colour:__________

Consistency: □ Thin □ Thick □ Clots

Accompanying Symptoms: □ Cramps □ Headaches □ Constipation □ Diarrhea

Vaginal Discharge: □ Present □ Absent □ Colour White/ Yellow/ Green / Red/ Black

□ Thick/ Thin □ Turbid/ Sticky □ Odour Yes/ No □ Foul Yes/ No

10. **Men's Conditions:** □ Decreased Libido □ Kidney Stone □ Impotence

□ Premature Ejaculation □ Nocturnal Emission

11. **Energy Level:** ___/10 After Waking ___/10 After Eating ___/10 Before Bedtime

12. **Stress Level:** ___/10 Why? ____

13. **Emotions:** □ Calm □ Explodes □ Depressed □ Anxious □ Sighs □ Irritable

Lifestyle:

Allergies: Smoking:

Exercise: Drinking:

Profession: