



2418 Lakeshore Road West
Oakville, ON L6L 1H7

Acupuncture

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/____ Age: ____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____

Occupation: _____ Where did you find our number? _____

If online, what site referred you? _____

Health History

What is your major health concern?

Have you tried Acupuncture before? Yes No

Medical History (please include dates and indicate if familial)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Allergies | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizure | | |

Please write down details for any items checked above or other significant illnesses / trauma:

Please list all medications you are taking (include length of use):

Prescription: _____

Non-prescription (eg. aspirin, antacids, vitamins, herbs): _____

Family Medical History (please indicate relationship)

- | | | | |
|--|---------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other: | | | |

List any other problems that you would like to discuss: _____

Inquiry

Chief Complaint: _____

History of the Present Condition

Onset of present condition: _____

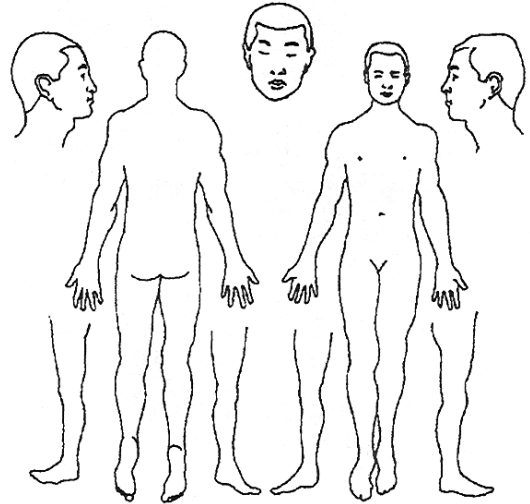
Diagnosis by family physician: _____

Location of pain and discomfort: _____

Time of greatest discomfort: _____

Additional Information: _____

Other treatments or therapies: _____



Informed Consent – Acupuncture and Cosmetic Acupuncture

Please take time to read this form, which will provide you with some basic knowledge about acupuncture treatment. While receiving acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles/laser and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, slight bleeding, mild pain in the area treated, brief generalized fatigue, tingling or numbness.

Everyone responds to treatment differently; therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let the practitioner know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly.

Cancellation Policy

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning there is a charge of \$45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the regular fee.

By signing this informed consent, you (the patient) acknowledged that you have read the information above carefully and are giving consent for treatment.

Signature (18 years of age or older): _____ Date: _____

Parental/Guardian Signature: _____ Date: _____