Health History Form

Please complete form in full.

Name: ______________________________ Date of birth: ______________________________

Address: ______________________________ City: ________________ Postal code: ____________

Phone: home: ______________________________ Email address: ______________________________

cell: ______________________________ Occupation: ______________________________

work: ______________________________ Referred by: ______________________________

Emergency contact name and number: ____________________ How do you hear about us: ____________________

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future please let us know. All information gathered is confidential except as required by law. You will be asked to provide written authorization for release of any information.

Please indicate conditions you are experiencing or have experienced.

Cardiovascular
- High blood pressure
- Low blood pressure
- Heart attack
- Heart disease
- Phlebitis
- Varicose veins
- Pacemaker or similar device
- Stroke/CVA Date: ____________
- Family History of any

Respiratory
- Chronic cough
- Shortness of breath
- Bronchitis/Pneumonia
- Asthma
- Emphysema
- Smoking
- Family History of any

Head/Neck
- Vision problems
- Vision loss
- Ear problems/Tinnitus
- Hearing loss
- Headaches/Migraine
- Type: ______________
- Family History of any

Soft tissue/joint
- Neck
- Low / Mid / Upper back (circle one)
- Shoulders
- Arms R / L
- Legs R / L
- Knees R / L
- Hip
- Elbow
- Other: ____________________

Infections
- Hepatitis/liver issues
- TB
- HIV
- Plantar warts
- Other: ____________

Other Conditions
- Loss of sensation
- Diabetes
- Allergies
- Epilepsy
- Cancer
- Arthritis
- Family History of any

Women
- Menstrual problems
- Menopausal
- Children: __________
- Pregnant
- Due date: ____________
- Breast lumps
- Hysterectomy

Skin
- Skin conditions
- Skin irritations
- Bruise easily
- Rashes

Mental Health
- Depression
- Anxiety
- Other: ______________
- Family History of any

Gastrointestinal
- Irritable Bowel Syndrome
- Chronic Abdominal Pain
- Prolonged Constipation
- Crohn's
- Colitis
- Poor appetite
- Excessive hunger/thirsty
- Belching/gas
- Nausea/vomiting
- Distress from greasy food
- Diarrhea
- Ulcer
- Metallic taste

What is your general health status? ______________________________

Current Medications: ______________________________ Condition it treats: ____________________

Previous Surgery (date & nature): ______________________________

Previous Injury (date & nature): ______________________________ (eg: Dislocation/fracture/car accident)

Other Medical Conditions (e.g. digestive disorders, gynaecological problems): ______________________________

Of Special Note (presence of internal pins, wires, special equipment): ______________________________

Primary Care Physician (name & phone number): ______________________________

Other Healthcare (e.g. chiropractor, naturopath, physiotherapist): ______________________________

Do you exercise regularly (i.e. 3 times per week) Yes No If yes, what do you do: ______________________________

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Have you received acupuncture therapy or Traditional Chinese Medicine treatments before? Yes No

If so, date of last : ____

What is the reason you are seeking Acupuncture or Traditional Chinese Medicine therapy?

____

Appointment Booking and Policies

Please read the following requirements carefully:

	Initial
24 hours notice, during business hours (Monday thru Saturday) is required for cancelling appointments, otherwise you will be charged a non-cancellation fee equivalent to the original appointment fee	
If you miss or do not show up for your appointment you will be charged a non-cancellation fee equivalent to the original appointment fee	
Payment is due upon completion of treatment. Form of Payment accepted is cash, cheque or e-transfer	
I have been made aware of the fee schedule and agree to such rates prior to treatment	
I will advise the clinic prior to treatment whether I require a receipt for registered massage, as registered massage therapy can only be provided by registered massage therapists and must be scheduled as such. I acknowledge that receipts for registered massage therapy will not be issued unless service was provided by a registered massage therapist.	
I have been advised that Tuina massage is a discipline of Traditional Chinese medicine, will **not** qualify for a registered massage receipt and will have a receipt issued as "acupuncture", not "RMT" (registered massage therapy).	
Tuina massage may be performed by either a male or a female staff member. If you do not want either a male or a female to perform Tuina on you, we ask that you advise the clinic's staff of this at booking or prior to the treatment beginning. The clinic will accommodate this request if we have been advised. If you do not express a preference, you are providing consent to treatment by either a male or a female.	

Extended Healthcare Coverage

We do not offer direct billing however we will provide a receipt that can be forwarded to your insurance provider if coverage exists. Please check coverage with your insurance provider in advance of your appointment as to whether you have acupuncture and/or registered massage therapy coverage.

If you know what coverage you have for Acupuncturist services please note it here for your file.

Annual Limit: $______________

Informed Consent Waiver

From this point forward, I hereby request and consent to the performance of acupuncture and other procedures within the scope of the practice of Traditional Chinese Medicine practitioner and acupuncturist, by Jinna Zheng or Xiyu Huang. I understand that methods of treatment may include, but are not limited to, needling and/or electro acupuncture; cupping; moxibustion; acupressure and/or tuina; diagnostic palpation on various areas of the body, Chinese herbal medicine, and nutritional and/or lifestyle counselling.

I know that all insertion needles are pre-sterilized and disposable.

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I will discuss with the Traditional Chinese Medicine practitioner or acupuncturist the nature and purpose of acupuncture or Traditional Chinese Medicine and other disciplines within Traditional Chinese Medicine. I understand that I have the right to be informed about all treatments and may seek opinions from other healthcare professionals or terminate therapy at any time.

I understand and am informed that in the practice of Traditional Chinese Medicine, as in the practice of Western Allopathic Medicine, there are some side effects and/or risks of treatment. I understand that although these are unlikely to occur, they are possible.

Possible side effects include but are not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, lung injury, and infection.

I do not expect the acupuncturist or Traditional Chinese Medicine practitioner to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist or Traditional Chinese Medicine practitioner to exercise such judgment based on the known facts to be in my best interest during the course of my treatment. I understand that results are not guaranteed.

Further, I will immediately notify the acupuncturist or Traditional Chinese Medicine practitioner of any unanticipated or unpleasant effects associated with any treatment.

Female Patients: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) or other Traditional Chinese Medicine disciplines is possible. I hereby state that I will inform the acupuncturist or Traditional Chinese Medicine practitioner if I am pregnant or if there is any possibility that I am pregnant.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of acupuncture and Traditional Chinese Medicine treatments and other procedures, and have had an opportunity to ask questions. 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 from this clinic.

____
Date

_________________________ ______________________________
Patient Name Patient or Representative Signature

_________________________ ______________________________
Practitioner Name Practitioner Signature

Jinna Zheng-R.Tcmp, R.Ac., #538
Xiyu Huang-R.Tcmp, R.Ac., #3142

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