ACUPUNCTURE**BLUE**

Patient Information and Consent Form

Please read the following carefully. If there is anything you do not understand, please ask.

What is Acupuncture?
Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. When indicated, additional methods of treatment such as the use of electrical stimulation of needles, Tui Na Massage, moxibustion, cupping (application of suction to the acupuncture points), and gua sha(skin scraping) may be used during treatment.

Is Acupuncture Safe?
You need to be aware that:
Drowsiness occurs after treatment in a small number of patients

Minor bleeding or bruising occurs after acupuncture in about 3% of treatments

Pain during treatment occurs in about 1% of treatments

Symptoms may get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign.

Lightheadedness may occur in new patients, due to hunger, extreme fatigue, or nervousness.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important that you let your practitioner know:

If you have ever experienced fainting or seizures

If you have a pace maker or any other electrical implants

If you have a bleeding disorder

If you are taking anti-coagulants (blood thinners) or any other medication

If you have a heart condition, diabetes, high blood pressure, HIV, hepatitis, or any other risk of infection

If you are pregnant, suspect you may be pregnant, or are attempting to conceive

Single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information. By signing this form, I consent to receive acupuncture treatment and such additional methods of Chinese Medicine treatment as may be agreed to, Including laser and auricular retention needles, between myself and Jeff McMackin.
I understand that I can refuse treatment at any time.

Signature: Date:

Print name in full: Practitioner:

Patient Information   Confidential

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Please take a moment to provide some information about yourself and your health conditions so that I may do my bes to treat you. This information is privileged practitioner/client communication and will be held in confidence.

Name:____Date:_______________

Age:_________Date of Birth*: DD/MM/YY*   Sex: ☐ M ☐ F   Marital Status: ____________

Address:____

City:______________________________Province___________________Postal Code:_________

Home Phone:_________________ Work Phone:__________________ Cell Phone:__________________

Email:___________________________________Occupation:_____________________________

Family Physician:___________________________________Phone:___________________________

How did you find out about us? _______________________Have you tried acupuncture before?______

Contact in case of emergency:_________________________________Phone:________________

Medical History

What is your major complaint or condition you want to improve?__________________________

____

What have you done to get relief?____

Have you seen your family doctor for this condition? ☐**Y** ☐**N** Specialist?__________________

Have you received a medical diagnosis? ☐ **Y** ☐ **N** ______________________________________

Are you now under medical or other therapeutic treatment? ☐ **Y** ☐ **N**_____________________

____

Significant Illnesses (please check all that apply):

☐Arthritis	☐Blood Clots	☐Heart Attack	☐Lupus
☐Anemia	☐Cancer	☐Heart Disease	☐Multiple Sclerosis
☐Aneurysms	☐Diabetes	☐Hemophilia	☐Osteoporosis
☐Autoimmune disease	☐Emphysema	☐Hepatitis	☐Rheumatic Fever
☐AIDS	☐Fibromyalgia	☐Kidney Disease	☐Thyroid Disease

Allergies:____

List any medications that you are presently taking: (include past 6 months)

Medication	Strength	How many per day	For how long
________________	____________	________________	__________
________________	____________	________________	__________
________________	____________	________________	__________
________________	____________	________________	__________
________________	____________	________________	__________

List any surgeries you have had:____

____

Significant trauma (auto accidents, falls, etc.)_____________________________________ __

____

What are your expectations of acupuncture treatments?________________________________

____

Health History **Confidential**

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Check off what you have experienced over the past 6 months.

General

☐Chills	☐Low Energy	☐Sweat spontaneously	☐Excessive thirst
☐Fevers	☐Fatigue	☐Lack of sweating	☐Nervousness
☐Aversion to cold	☐Dizziness	☐Night Sweating	☐Weight Loss
☐Aversion to heat	☐Numbness	☐insomnia	☐Weight Gain

Head and Neck

☐Headaches	☐Nasal obstruction	☐Recurrent sore throats	☐Blurry Vision
☐Migraines	☐Nasal discharge	☐Phlegm in throat	☐Dry/burning eyes
☐Heaviness in head	☐Loss of Smell	☐Sores on tongue	☐Eye pain/strain
☐Sinus problems	☐TMJ/jaw pain	☐Taste change	☐Ringing in ears
☐Nosebleeds	☐Teeth problems	☐Hoarseness	☐Hearing Loss

Musculo-Skeletal

Pain, weakness or numbness in:		☐Knee problems	☐Spasms/cramps
☐Neck	☐Hips	☐Low back pain	☐Tendonitis
☐Shoulders	☐Legs	☐Pain all over	☐Broken Bones
☐Arms	☐Feet	☐All over weakness	☐Osteoporosis
☐Hands	☐Joints	☐Lack of Strength	☐Scoliosis

Cardiovascular

☐High blood pressure	☐Cold hands or feet	☐Asthma	☐Coughing blood
☐Low blood pressure	☐Swelling of ankles	☐Hay Fever	☐Bronchitis
☐Chest Pain	☐Varicose Pain	☐Allergies	☐Phlegm production
☐Irregular heart beat	☐Rib side pain	☐Shortness of breath	☐Difficulty inhaling
☐Poor circulation	☐Distention in chest	☐Persistent cough	☐Difficulty exhaling

Neurologic

☐Fainting	☐Paralysis	☐Tremor	☐Vertigo
☐Convulsions	☐Stroke	☐Recent Clumsiness	☐Twitching of face
☐Handwriting change	☐Seizure/Epilepsy	☐Drowsiness	☐Spinal cord injury

Gastrointestinal

☐Abdominal pain	☐Ravenous appetite	☐Diverticulitis	☐Nausea
☐Bloating	☐Constipation	☐Bloody Stools	☐Vomiting
☐Belching	☐Diarrhea/loose stools	☐Black stools	☐Vomiting Blood
☐Gas	☐IBS	☐Difficulty swallowing	Other:
☐Poor appetite	☐Hemorrhoids	☐Heartburn/reflux	

Genitourinary

☐Dilute urine	☐cloudy urine	☐Scanty urine	☐Urgency
☐Dark urine	☐Burning urination	☐Profuse urine	☐Nighttime urination
☐Blood in urine	☐Frequent urination	☐Poor bladder control	☐Recurrent UTI's

Emotional

☐Depression	☐Irritable	☐Vegetarian	☐Smoker
☐Anxiety	☐Often feel angry	☐Eat a lot of sweets	☐Recreational drugs
☐Grief/Sadness	☐Mind not clear	☐Eat a lot of fried foods	☐Exercise in excess
☐Worry/Overthinking	☐Poor memory	☐High caffeine intake	☐Shift work
☐Fear	☐Difficulty concentrating	☐Eating Disorder	

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