ACUPUNCTUREBLUE

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 best 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?_______________________________

____

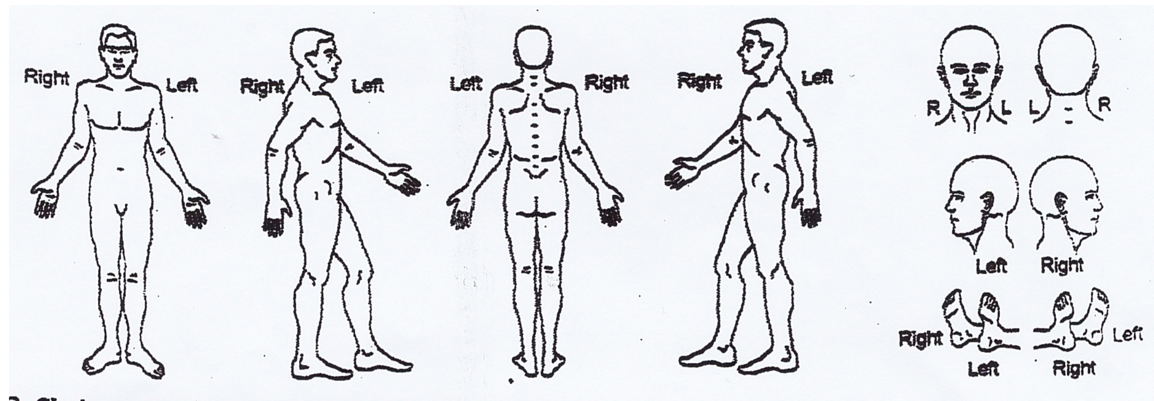
Initial Pain Assessment Tool

Patient name: ______________________________________ Date: _______________________

1. Where is your pain? ____

2. Have you received a medical diagnosis? Yes__ No__ ____________________________________

Please shade all areas of pain and/or discomfort:



3. Circle the words that best describe your pain.

Aching	sharp	penetrating	shooting	stabbing
Throbbing	tender	nagging	gnawing	burning
Numb	tiring	exhausting	unbearable	spasmodic

Circle one: occasional continuous

Does your pain radiate/refer? Yes No **Where to? ____________________________________**

What time of day is your pain the worst? Circle one.

Morning afternoon evening nighttime

4. Intensity of pain.

Rate your pain at it's worst:
(No pain)0 1 2 3 4 5 6 7 8 9 10(severe)

Rate your pain at it's best:
(No pain)0 1 2 3 4 5 6 7 8 9 10(severe)

Rate your pain on average:
(No pain)0 1 2 3 4 5 6 7 8 9 10(severe)

Rate your pain right now:
(No pain)0 1 2 3 4 5 6 7 8 9 10(severe)

Initial Pain Assessment Tool

5. When did your pain start? ____________________ What caused it? __________________________

6. What makes your pain <u>better</u>? ____

7. What makes your pain <u>worse</u>? ____

8. What <u>treatments</u> or <u>medicines</u> are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide (s) you.

a) _____________________________(No relief) 0 1 2 3 4 5 6 7 8 9 10 (complete relief)
Treatment or Medicine (include dose)

b) ____________________________ (No relief) 0 1 2 3 4 5 6 7 8 9 10 (complete relief)
Treatment of Medicine (include dose)

c) ____________________________ (No relief) 0 1 2 3 4 5 6 7 8 9 10 (complete relief)
Treatment or Medicine (include dose)

d) ____________________________ (No relief) 0 1 2 3 4 5 6 7 8 9 10 (complete relief)
Treatment or Medicine (include dose)

9. Have you had any of the following tests done? Please circle. Provide a written report if possible.

xray CT scan MRI ultrasound bone scan nerve conduction test blood work

10. Effects of pain. Please describe:

Accompanying symptoms (e.g., nausea, fatigue)____

Sleep ____

Appetite ____

Physical activity ____

Normal work ____

Mood____

Stress levels ____

Ability to concentrate____

Relationship with others (e.g., irritability)____

Other____

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Health History

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

General

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

Head and Neck

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

Musculo-Skeletal

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

Cardiovascular

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

Neurologic

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

Gastrointestinal

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

Genitourinary

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

Emotional

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