PATIENT/CLIENT INTAKE FORM

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Lastname:_____ Name: _____ Gender: M __ F __Date Of Birth: _____
(mm/dd/yyyy)

For Office Use Only
Driver's License Number: _____ Photo Id: Y N

Place Of Birth:_____ _____Years In Canada: _____
Address: _____ Apt: _____ City: _____
Postal Code: _____ Home Phone: _____Bus: _____
Cell: _____ Email: _____ Occupation: _____
Doctor's Name:_____ _____
Adress:_____ _____Phone: _____
Who May We Thank For Referring You To Our Care? _____
name of family member, friend, co-worker, internet, yellow pages, street sign etc.
Are You Currently Seeing A Health Professional For Your Condition? Yes/No
Please Explain: _____
Have You Done Acupuncture Before? Yes/ No
What Is Your Major Health Concern? _____

Personal Medical History (Past and/or present)

[]Cough	[]Heart disease	[]AIDS/HIV	[]Sexually Transmitted	[]Pain
[]Wheezing	[]Palpitations	[]Anemia	Disease/Infection	[]Trauma
[]Shortness of breath	[]Insomnia	[]Haemophilia	[]Thyroid condition	[]Hospitalization
[]Bronchitis	[]Angina	[]Diabetes	[]Arthritis	[]Cancer
[]Asthma	[]Stroke	[]Hepatitis	[]Bone disease	[]Vertigo
[]Allergies	[]Irregular heart beat	[]Herpes	[]Fibromyalgia	[]Migraines
[]Skin conditions	[]Poor circulation	[]Kidney disease		

Females:	**Males:**	**Other:**	
[]Pregnancy	[]Prostate disease	[]High blood pressure	[]Poor memory/concentration
[]Miscarriage/Abortion	[]Impotence	[]Low blood pressure	[]Depression
[]Menopause	[]Premature	[]Increased/Decreased libido	[]Anxiety
[]Irregular menstruation	ejaculation	[]Hemorrhoids	[]Hair loss
[]Late age of first menses	[]Erectile dysfunction	[]Hernia	[]Other
[]Infertility		[]Urinary problems	Please specify:_____
[]Vaginal discharge			

Please include any details (including dates) for the items checked above, or list any other significant conditions, illnesses, or traumas: _____

CURRENT MEDICATION:

Name: _____ Condition treated: _____
_____ _____

DO YOU TAKE REMEDIES OR SUPPLEMENTS? YES NO

Consent to Acupuncture Treatment

Completion of this consent form is mandatory before any treatment will be given

I understand that Acupuncture involves the penetration of the skin by the use of pre-sterilized, disposable, one-time use needles. In addition, other modalities, such as Moxibustion, Guasha (skin-scraping), cupping, Tuina (Chinese massage), acupressure, blood-letting, exercise therapy, nutritional counselling, Chinese herbal medicine, or the use of a heat lamp may be used during the course of treatment.

- I understand that I may experience temporary soreness, bruising, light-headedness, dizziness, or drowsiness following a treatment.
- I understand that, despite all precautions taken to avoid any harm, there are possible risks of an acupuncture treatment, including infection, bleeding, burns, fainting, numbness, and tingling, swelling, or skin irritation. I do not expect my Acupuncturist to anticipate all risks or complications. In addition, I understand that I must disclose any health conditions or immune problems so that special precautions can be made if necessary.
- I understand that while Chinese herbal medicines/prescriptions are traditionally considered safe, there may be possible side effects, including stomach ache, nausea, vomiting, or diarrhea.
- I understand that acupuncture may not provide immediate or instant cure of my condition(s), that more than one (1) session may be necessary, and that results are not guaranteed. I also understand that my condition(s) or related symptoms may worsen before improvements are seen.
- I understand that, in addition to treatments received, there may also be dietary and/or lifestyle changes that are required. I accept that it is my responsibility to follow these recommendations to optimize my chances for successful treatment of my condition(s).
- I understand that treatments may require the removal of clothing, and it is my responsibility to inform the practitioner if there are any areas of my body I do not wished to be treated or touched due to personal or religious reasons. I also understand that by doing so, treatment plans may become modified, and subsequently the course of treatments may become longer.
- **For Cosmetic Acupuncture/Facial Rejuvenation:** I understand that, in addition to the items listed above, Cosmetic Acupuncture does not provide permanent results due to the natural aging process. I understand that maintenance treatments may be necessary after my initial course of treatments. I also understand that individual results may vary due to aging and lifestyle factors. I understand that there is the risk of allergic reactions to any topical treatments used, and that it is my responsibility to inform my Acupuncturist of any allergies and skin sensitivities prior to treatment.
- I confirm that I: currently am not pregnant, do not suspect that I may be pregnant, suffer from a bleeding disorder, or have a pacemaker.
- I am aware that acupuncture is currently not covered by OHIP and that it is my responsibility to provide payment for all services and products rendered, and that it is my responsibility to determine whether my health insurance provider will cover the costs of my treatments.
- I confirm that all information provided in the Medical History form is accurate to the best of my knowledge.
- I understand that InsideOut Wellness Centre can provide courtesy notification for my appointments via text, e-mail or telephone. It is my responsibility to note the time and date of all my appointments. I understand that a minimum of 24 hours notice is required to change or cancel my appointment.

By signing this consent form, I confirm that I have read this form in its entirety and understand all contents listed above. I agree to accept all Acupuncture treatments and their related modalities provided by _____

This consent form will be in effect for the entire course of my treatments for my present condition(s) and any future conditions for which I seek treatment.

Patient's name (Please print):_____

Patient's signature:_____ Date:_____