



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.

| | | | | | |
|--|------------------------------|----------------------------|--|--------------------------|--|
| Full Name | | | | | |
| Date of Birth (MM/DD/YYYY): | | | | Gender: Male or Female | |
| Place of Birth: | | | | Years in Canada: | |
| Cell Phone: | | Home Phone: | | Work Phone: | |
| Email Address: | | | | | |
| Address: | | | | Apt #: | |
| City: | | Province: | | Postal Code: | |
| Occupation: | | | | | |
| Who may we thank for referring you to our care? | | | | | |
| General Health Background: | | | | | |
| Physician Name: | | | | | |
| Allergies: | | | | | |
| Are you currently on any medications? | | | | | |
| Are you currently seeing a Health Professional for your Condition? Please explain. | | | | | |
| Have you done acupuncture before? YES or NO | | | | | |
| What is your major health concern? | | | | | |
| Personal Medical History (Past or Present): | | | | | |
| Cough/Bronchitis | Heart Disease | AIDS/HIV | Sexually Transmitted Disease/Infection | Pain | |
| Immune Disorder | Palpitations | Anemia | Thyroid Condition | Trauma/Accidents | |
| Shortness of Breath | Insomnia | Blood Disorder | Arthritis | Hospitalization | |
| Lung Disease | Angina | Diabetes | Bone Disease | Vertigo | |
| Asthma | Stroke | Hepatitis | Fibromyalgia | Migraines | |
| Allergies | Irregular Heart Beat | Herpes | Cancer | Skin Conditions | |
| Poor Circulation | Kidney Disease | Liver Disease | Epilepsy/Seizures | Surgery | |
| High Blood Pressure | Low Blood Pressure | Increased/Decreased Libido | Hemorrhoids | Hernia | |
| Urinary Disorder | Poor Memory or Concentration | Depression/Anxiety | Digestive Disorders | Hair Loss | |
| Other (Please Specify): | | | | | |
| Females: | | | | | |
| Pregnancy | Miscarriage/Abortion | Menopause | Irregular Menstruation | Late age of first menses | |
| Infertility | Vaginal Discharge | Endometriosis | Ovarian Cysts | | |
| Males: | | | | | |
| Prostate Disease | Impotence | Premature Ejaculation | Erectile Dysfunction | | |

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 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, 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 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 wish 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 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 notifications 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 _____.

InsideOut Wellness Centre is the custodian of my file. My file will only be released with a duly executed authorization form signed by me.

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.

Client Name (Printed): _____

Client Signature: _____ Date: _____