Leduc Wellness Centre Acupuncture

CONFIDENTIAL PATIENT HEALTH RECORD

Today's Date: _____

Name: (First) _____ (Middle) _____ (Last) _____
Date of Birth: _____/_____/_____ **Sex:** Male ☐ Female ☐
mm dd yr

Phone: (Cell) _____ (Home) _____
Email (appointment reminders and/or receipts):
_____
Mailing address: _____
City, Province, Postal Code: _____

Occupation: _____ **Business Phone:** _____

Family physician: _____ **Phone:** _____

Emergency Contact Details:
Name: _____ Phone: _____ Relationship: _____

How did you hear about Leduc Wellness Centre? _____

Please complete the following pages so that I can better meet your healthcare needs. If you have any questions, please do not hesitate to ask.

Reason(s) for Visit: (E.g. Headaches)	**Onset:** (E.g. June 2014)	**Frequency:** (E.g. 2x/week)	**Severity:** (E.g. Scale 1-10)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Past Medical History:

_____
_____
_____

Family Medical History:

Mother: _____
Father: _____

Surgeries (Major/Minor):

_____
_____

Injuries:

_____

_____

Lifestyle Habits:

Tobacco: Y ☐ N ☐ Packs/Day: _____
Alcohol: Y ☐ N ☐ Drinks/Week: _____

Other Drugs: _____

Allergies:

_____

_____

Medications/Supplements (present)**:**

_____

_____

What physical activities do you participate in?

_____

_____

What do you do to relax?

_____

_____

How's your sleep? (insomnia, wake up tired, etc.)**:**

_____

_____

Major stressors in your life:

_____

_____

Diet (typical breakfast, lunch, dinner)**:**

_____

_____

_____

Cravings:

_____

How much water do you drink per day? _____
How much caffeine do you drink per day? _____

How is your digestion (heartburn, nausea, stomach pain, etc.)**?**

_____

_____

How are your bowel movements (diarrhea, constipation, etc.)**?**

How often do you have a bowel movement (per day, per week)**?**

How is your urination (difficulty in, burning pain, frequent, etc.)**?**

Cardiovascular Health (hypotension, hypertension, etc.)**:**

Respiratory Health (asthma, persistent cough, shortness of breath, etc.)**:**

Eyes (floaters, blurry vision, etc.)**:**

Ears (ringing, deafness, infections, etc.)**:**

Nose (chronic congestion, nosebleeds, etc.)**:**

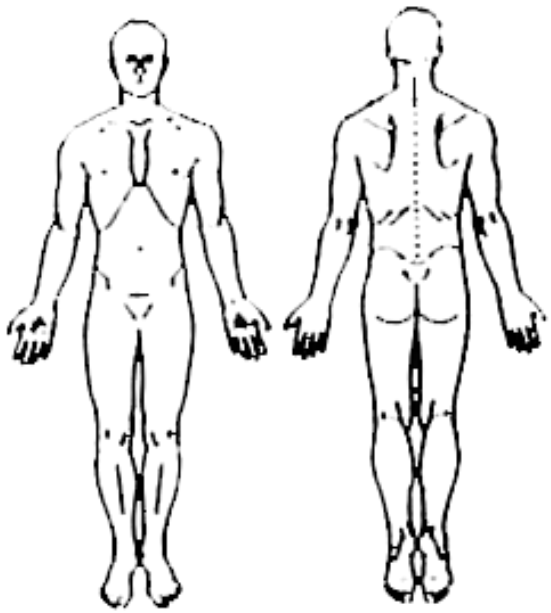
Throat (reoccurring sore throat, difficulty swallowing, etc.)**:**

Head (headaches, TMJ, grinding teeth, etc.)**:**

Skin & Hair (acne, rashes, eczema, hair loss, etc.)**:**

Neuropsychological Conditions (depression, tics, seizures, anxiety, etc.)**:**

Indicate where you have pain:



X - Sharp

D - Dull

N - Numbness

P - Pins & Needles

Women Only:

Menstrual History

Age of first period: _____ Periods Regular: Y ☐ N ☐ Days between periods: **_____**
Duration of Period: _____ Do you bleed between cycles? Y ☐ N ☐

PMS Symptoms:	**None**	**Before**	**During**	**Mid Cycle**
Emotional	☐	☐	☐	☐
Breast Swelling	☐	☐	☐	☐
Breast Tenderness	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Bloating	☐	☐	☐	☐
Cramps	☐	☐	☐	☐

Are you using a Contraceptive? Y ☐ N ☐
What Type: _____

History of Pregnancies:

_____

Menopausal: Y ☐ N ☐
Symptoms:

_____

INFORMED CONSENT TO ACUPUNCTURE CONSULTATION AND TREATMENT

I, _____, hereby request and CONSENT to utilizing any combination of the following: acupuncture, herbal prescriptions, Chinese physical therapy (Tui na), cupping, gua sha to be performed by the acupuncturist.

I understand with acupuncture treatment that there are some very slight risks to treatment, including but not limited to: bruising, minor bleeding, pain and discomfort. I understand that sterile, single use needles are used in all treatments.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of the therapy mentioned above. I understand that results are not guaranteed.

Should I have to cancel an appointment for any reason, I agree to give the therapist 24 hours' notice or I will be billed 50% of the cost of the appointment missed.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above mentioned modalities of treatment. I intend this consent form to cover the entire course of treatment for any and all conditions treated by the acupuncturist.

I have consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought.

Section 8(1) of Alberta's Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless

- *(d) That person has already consulted with a physician or, in the case of dental pathology, a dentist about the condition for which care and treatment from the acupuncturist is being sought;*
- *(e) (b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and*
- *(f) The acupuncturist has completed a patient consultation form.*

_____ Date: _____, 20____.
Signature of Client

Consent to treatment of minor - by my signature, I hereby authorize my child or dependant to have acupuncture treatments administered.

_____ Date: _____, 20____.
Signature of Parent/Legal Guardian