Leduc Wellness Centre Acupuncture

CONFIDENTIAL CLIENT HEALTH RECORD

Name: _____ Sex: ☐ Female ☐ Male

Email (appointment reminders and/or receipts): _____

Telephone: Cell: _____ Residence: _____

Address: _____

City/Province: _____ Postal Code: ___ ___ ___ - ___ ___ ___

Occupation: _____ Business Phone: _____

Age: _____ Date of Birth: _____/_____/_____
mm dd yr

Emergency Contact Details:

Name: _____ Relationship: _____ Phone: _____

Have you ever received acupuncture care? ☐ No ☐ Yes - If yes:

Where: _____ Approximate date of last visit: _____

Whom may we thank for referring you to our office? _____

PLEASE READ:

INITIAL VISIT: $135
PER VISIT FEE: $90

Fees are due at time of service unless other arrangements have been previously made.
A Fee may be charged for late, cancelled, or no show appointments.

Signature: _____ Date: _____

For dependent children under 18, name of parent(s) /guardian: _____

Parent/guardian with custodial rights must sign.

About Your Health

There are many events that occur and habits that we acquire up throughout our lifetime which can cause accumulated stress in the body, resulting in a loss of health potential. Most times these effects are gradual, not even noticed until they become serious. Answering the following questions will give us a good understanding of your overall health, both past and present, and allow us to better assess your body's optimal health potential.

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

Past Illnesses, surgeries, or major injuries:

Family History (Cancer, Stroke, Heart Disease/Blood Pressure):

Maternal:

Paternal:

How much water do you drink per day?

How much caffeine do you drink per day?

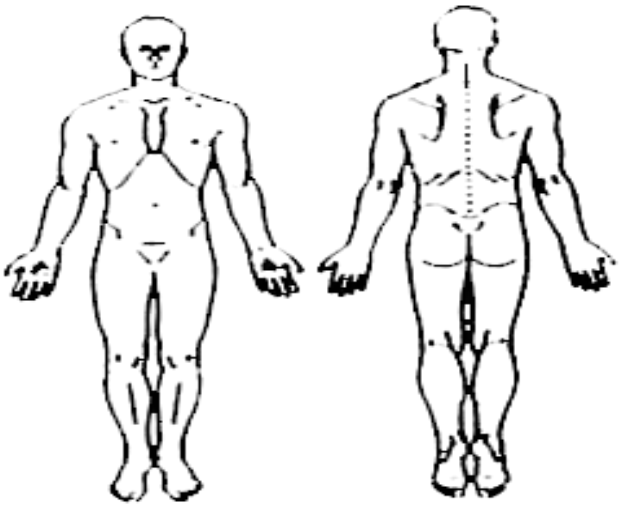
How is your digestion (heartburn, nausea, stomach pain, etc.)?

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

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

Eyes (floaters, blurry vision, glasses, contact lenses, etc.):

Please indicate where and how you experience pain:



X - Sharp

D - Dull

N - Numbness

P - Pins & Needles

Health History

To give the Acupuncturist a complete picture of your overall health, please check off **ANY** of the following symptoms you have EVER experienced, even if you don't think they are related to the current problem:

Soft tissue/joints
- ☐ tendonitis/bursitis
- ☐ weakness: _____
- ☐ sprains/strains
- ☐ arthritis OA/RA/other
- ☐ herniated disc

Headaches
- ☐ migraines
- ☐ tooth/jaw/ear pain
- ☐ tension
- ☐ head trauma/concussion date: _____

Accident/Injury
- ☐ car accident
- ☐ whiplash
- ☐ symptoms: _____
- ☐ physical limitations: _____

Skin
- ☐ bruise easy
- ☐ varicose veins
- ☐ athletes foot
- ☐ warts/plantar warts
- ☐ loss of sensation
- ☐ acne
- ☐ eczema
- ☐ rash
- ☐ hair loss

Women
- ☐ pregnancy due date: _____
- ☐ gynecological conditions
- ☐ uterine bleeding
- ☐ fibroids
- ☐ endo
- ☐ polys
- ☐ pcos

Infectious Disease
- ☐hepatitis A / B / C
- ☐tuberculosis
- ☐HIV / AIDS
- ☐ Herpes
- ☐Oral
- ☐Genital

Respiratory
- ☐ pneumonia
- ☐ shortness of breath
- ☐ bronchitis
- ☐ sinus problems
- ☐ chronic cough
- ☐ asthma
- ☐ emphysema
- ☐ tightness in chest
- ☐ difficulty swallowing

Other:_____
_____
_____
_____
_____
_____

Cardiovascular
- ☐ pacemaker
- ☐ heart attack
- ☐ phlebitis
- ☐ stroke
- ☐ heart disease
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ blood clot
- ☐ nosebleeds
- ☐ palpitations
- ☐ hemophilia

Other Conditions
- ☐ neurological conditions
- ☐ epilepsy
- ☐ insomnia/poor sleeping
- ☐ vivid dreams
- ☐ nightmares
- ☐ anxiety
- ☐ depression
- ☐ kidney / bladder problems
- ☐ diabetes
- ☐ allergies specify: _____
- ☐ anaphylaxis
- ☐ cancer: _____
- ☐ vision problems
- ☐ fibromyalgia
- ☐ hearing loss or tinnitus
- ☐ constipation
- ☐ osteoporosis
- ☐ other digestive condition date: _____

Lifestyle Habits:

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

Other Drugs: _____

Female Specific Health History

Age of first period: _____ Periods Regular: ☐ N ☐ Y

Days between periods: _____ Duration of Period: _____

Do you bleed between cycles? ☐ N ☐ Y Irregular vaginal discharge? ☐ N ☐ Y

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

Are you using a Contraceptive? ☐ N ☐ Y

What Type:

_____

History of Pregnancies:

_____

Menopausal: ☐ N ☐ Y

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

- *(a) 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;*
- *(b) (b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and*
- *(c) 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