Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Acupuncture Intake Form

Intake Dr.			Current Date:
PERSONAL INFORMATION			
Last Name	First Name	Sex	Date of Birth:
Address			
City	Province	Postal Code	Telephone (cell)
Telephone (h)	Telephone (w)	Email	
If you would like to receive our Newsletters filled with monthly promotions and articles on maintaining a healthy lifestyle, please place a check mark: ☐			
Marital Status	Parents Name (if child)	Occupation	
Clinic has a news letter which includes upcoming events as well as health tips that we email once a month to patients. Would you like to receive our letter? Yes, No Thanks			
Emergency Contact		Phone	
Do you have or ever had: Aids Hepatitis A B C Other			
Referral: Self Physician Other (please specify) How did you hear about the clinic?			
Chief Complaints			

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Previous Medical History (Include: Previous illness name and dates, surgeries, traumas, illness in childhood)
Allergies
Family History of Health Problems
Currents Medications (Include: Drug name, dose, frequency taken, for how long, reason)
Current Supplements (Include: Supplement name, dose, frequency taken, for how long, reason)

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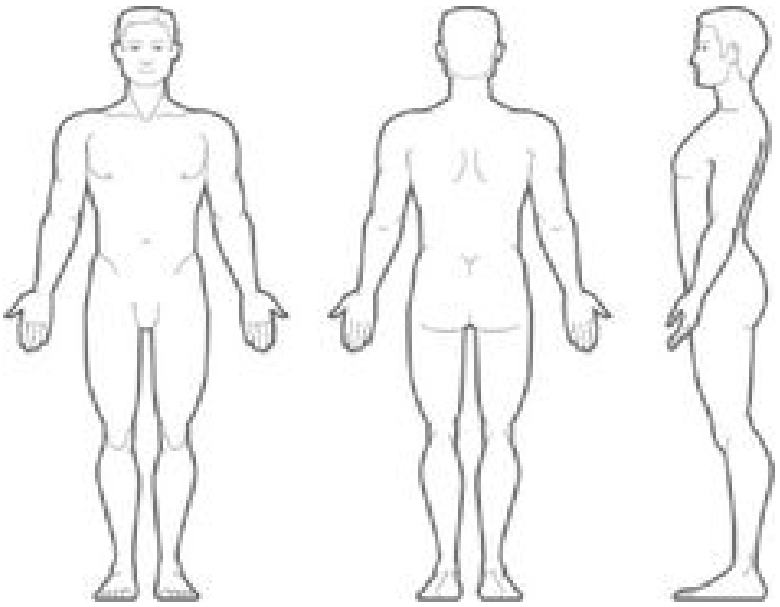
LIFESTYLE
Living Environment: ___ Dry; ___ Damp
Favorite Food and Drink Type: ___ Sour; ___ Sweet; ___ Salty; ___Greasy; ___ Spicy
Do you drink: ___ Coffee (No.__ cups); ___ Cold Drinks; ___ Warm Drinks
Do you use any of the following? ___ Cigarettes; ___ Alcohol; ___ Recreation Drugs
What are your major sources of stress?
Are you frequently in a state of: ___ fear; ___ worry; ___ anger; ___ sadness; ___ anxiety?
Please comment on your level of exercise (Type & Frequency)
Please indicate on the diagram where you are experiencing pain: 

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Patient Confirmation of Consultation with Physician

Alberta acupuncture Legislation states that an acupuncturist must not treat someone who has not consulted with a physician or, in the case of dental pathology, a dentist about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable box confirming that you have already seen a physician, or will be seeing one within 2 weeks of your first acupuncture treatment.

☐ I have already seen a doctor regarding the condition(s) that I am seeking treatment for

☐ I agree to see a doctor regarding the condition(s) that I am seeking treatment for within 2 weeks of my first acupuncture treatment at this clinic

Patient Consent Form for Acupuncture

I, hereby fully understand the acupuncture treatment process and the possible effects such as:

Fainting, small bruises, post-acupuncture sensation (numbness, tingling, heaviness and tiredness, temporary exacerbation of symptoms)

I agree to fully disclose all past and current health conditions. I give consent to have acupuncture treatment.

Signature _____ Date_____

Parent/Guardian Signature _____ Date _____

Cancellation Policy:

All appointments must be cancelled 24 hours in advance. If sufficient notice is not given to the clinic, a fee equal to the cost of the visit will be levied.