Wellness for the Body
Massage Therapy & Healing Centre

Acupuncture

2418 Lakeshore Road West, Oakville, Ontario L6L 1H7
Phone: 905.465.4595 Web: www.wellnessforthebody.com

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Please consider giving us a daytime phone number, in the event we need to reach you the same day as your appointment.

Phone: (H)_____ (M)_____ (B)_____

Gender: ☐ Female ☐ Male Occupation: _____

Email: _____ Would you like to receive our monthly e-newsletter? ☐ Yes ☐ No

Where did you find our number? _____

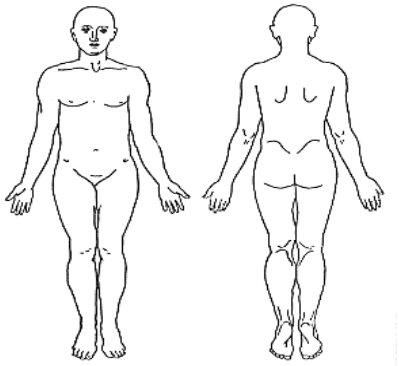
If online, what site referred you? ☐ Google ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other: _____

Health History

Reason for acupuncture: _____

_____

Indicate areas of pain or discomfort:



Notes: _____

_____

_____

_____

_____

Have you received acupuncture before? ☐ No ☐ Yes If yes, when was your last treatment? _____

List other current therapies (i.e. chiropractic): _____

Doctor: _____ Phone: _____ City: _____

Current supplements/medications (conditions they treat): _____

_____

Surgeries/Injuries (Please list and date): _____

_____

Please list the presence and location of any internal pins, wires, artificial joints or special equipment: _____

_____

please turn over...

Please check all applicable boxes (current or past conditions)

Cardiovascular:
- ○ High blood pressure
- ○ Low blood pressure
- ○ Chest pain
- ○ Chronic congestive heart failure
- ○ Heart disease
- ○ Myocardial infarction
- ○ Phlebitis
- ○ Cardio-vascular accident
- ○ Stroke
- ○ Pacemaker or similar device
- ○ Hypertension
- ○ Angina
- ○ Mitral Prolapse
- ○ Heart Palpitations
- ○ Varicose veins
- ○ Deep vein thrombosis
- ○ Blood clots
- ○ Poor circulation
- ○ Cold hands/feet
- ○ Lymphedema
- ○ Other _____

Skin:
- ○ Allergies (anaphylactic)
- ○ Rashes
- ○ Athletes foot
- ○ Warts
- ○ Cold sores
- ○ Eczema/psoriasis
- ○ Other (contagious) _____

Reproductive:
- ○ Pregnancy (due date: _____)
- ○ Menstruation:

__ Absent __Painful
__ Heavy __Light
__ Normal __Irregular
- ○ Dysmenorrhea
- ○ Menopause __Pre __Active __Post
- ○ Other _____

Nervous System:
- ○ Herpes/shingles
- ○ Numbness/tingling
- ○ Loss of sensation
- ○ Chronic pain
- ○ Fatigue
- ○ Sleep disorder/insomnia
- ○ Chronic fatigue syndrome
- ○ Memory Loss

Other _____

Respiratory:
- ○ Chronic cough
- ○ Bronchitis
- ○ Shortness of breath
- ○ Asthma
- ○ Emphysema
- ○ Smoking
- ○ Pneumonia
- ○ Other _____

Musculo-skeletal:
- ○ Fibromyalgia
- ○ Bone or joint disease
- ○ Tendonitis
- ○ Bursitis
- ○ Fractures
- ○ Osteoarthritis
- ○ Rheumatoid arthritis
- ○ Sprains/strains
- ○ Swelling
- ○ Stiffness
- ○ Spasms/cramps
- ○ Pain (check area)

__Jaw/TMJ __Neck
__Shoulder __Elbow
__Wrist __Hip __Knee
__Ankle __Low back
__Upper back __Mid Back

Digestive:
- ○ Poor digestion
- ○ Constipation
- ○ Gas/bloating
- ○ Nausea/vomiting
- ○ Diarrhea
- ○ Ulcer
- ○ Irritable bowel syndrome
- ○ Liver/gall bladder
- ○ Kidney/bladder issues
- ○ Kidney/gall stones
- ○ Other _____

Infectious Diseases:
- ○ Hepatitis
- ○ Tuberculosis
- ○ HIV
- ○ Venereal Disease
- ○ Herpes
- ○ Dermatitis
- ○ Other _____

Other:
- ○ Diabetes
- ○ Anemia
- ○ Dizziness
- ○ Vertigo
- ○ Earaches
- ○ Ringing in ears
- ○ Sinus problems
- ○ Loss of smell/taste
- ○ Vision/hearing loss
- ○ Thyroid issues
- ○ Hormone imbalance
- ○ Cancer
- ○ Epilepsy
- ○ Anxiety/depression
- ○ Panic Attacks
- ○ Headaches/migraines

How often: _____
- ○ Allergies:

__Food __Drug
__Environmental
- ○ Other _____

Client Consent Statement

In keeping with the Health Care Consent Act (1996), it is my choice to receive therapy. I, or the person listed below, have discussed with my Traditional Chinese Medicine Practitioner the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single–use needles to penetrate the skin. Additional treatment methods can include: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include: slight pain, soreness, bruising, bleeding or discoloration of skin. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying or believe to have any infectious agents, including, but not limited to, HIV, TB, and Hepatitis. In some cases, where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of my treatments. The length of my treatment depends on the severity of my condition.
6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have, and have received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatment.

Cancellation & Fee Policy (For a full detailed price list: www.wellnessforthebody.com)

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, there is a charge of $45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the full regular fee. Payment is due at the time services are rendered. This policy applies to all our patients. Patients with extended health care coverage should note, our office does not file claims on your behalf, nor bill your insurance company directly.

I understand and am aware of the Cancellation & Fee Policy. I also agree that if I am late for my appointment, I will receive the remainder of the appointment time and will be responsible for the full payment of the scheduled appointment.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____