Life 'n Balance
WELLNESS CENTRE

Acupuncture Intake Form

Please take time to fill out the following form. It provides a basis for further questions during your visit and helps properly assess your situation. All information is for office use only and will be kept confidential.

General:

Date of visit:___________________

First Name:______________________________ Last Name:____________________________________

Date of Birth: Y________M_________D________ Age: _______ Gender: Male □ Female □

Complete Address: ____

City: _________________ Postal Code: ________________ E-mail: _______________________

Phone Number: ____________________ text reminders? □ Secondary Number: _______________________

Occupation: ____________________________________ Full-time or Part-time? ____________

Marital Status: single □ married □ separated □ divorced □ other: ________________________

Extended Healthcare Insurance Company (if applicable):

____

In case of emergency contact: ____

Relationship to patient: ________________________ Tel. No. ___________________________

How did you find out about the Acupuncture services at this clinic? ___________________

The last physician or health care practitioner you've seen and when?

Chief Health Concerns:

What are your chief health concerns? (in order of importance to you)

Allergies:

Family History of Health Problems

Current Medications

Lifestyle

Please check all that apply.

Living Environment:

Dry □ Damp □

Favourite food and drink type:

Sour □ Sweet □ Salty □ Greasy □ Spicy □

Do you use any of the following?

Cigarettes □ Alcohol □ Recreation Drugs □

What are your major sources of stress (work, school, home etc)?

____
____
____

Please comment on your level of exercise (how many days per week, type etc).

____
____
____

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 conditions 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 two 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 Life 'n Balance Wellness Centre with Neelam Sandhu.

Please read and sign the following page, then hand this form back to the receptionist, thank you.

Life 'n Balance Wellness Centre

Patient Consent Form for Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, and including moxibustion, cupping, and/ or electroacupuncture by the doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding or bruising, pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor and exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to

Signature____ Date__________________________

Practitioner's Signature______________________________Date__________________________

Cancellation Policy: All appointments must be cancelled within 24 hours in advance. If sufficient notice is not given to the clinic, a fee equal 100% of the cost of the visit will be levied. The amount of the visit will be required to be paid out of pocket.

Signature____ Date__________________________