Acupuncture Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Acupuncture and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health. Acupuncturist asses the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Please advise your Acupuncturist if you are pregnant, suspect you are pregnant or if you are breastfeeding. By signing this form you acknowledge your understanding of the associated risks and accept full responsibility for any fees incurred during care and treatment and grant permission to proceed. 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, minor 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.

Privacy of your personal information is an important part of providing you with quality care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards of CTCMPAO (College of Traditional CHinese Medicine Practitioners and Acupuncturists of Ontario).

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Acupuncturist may discuss my case with other healthcare providers. I understand that I may look at my medical records at any time and can request a copy of my file with a fee of $0.10 per page. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect my Acupuncturist to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Acupuncture care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): ____
Signature of Patient or Guardian: ____ Date: ____________________
Acupuncturist: ________________________________ Acupuncturist Signature: ________________________

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: _______________________________

Billing Authorization Form

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Credit Card on File:

Client's Name: ____

Name as it appears on the credit card: ____________________________________

Type of credit card (please circle): MasterCard / Visa

Card Number: ____

Expiration Date (month/year): ________________

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, _______________________________________, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: ____ Date: ______________________

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Acupuncture Intake Form

Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care. It should take 15 – 20 minutes.

Contact Information:

Name ______________________________
Date of Birth M__________D________Y__________
Gender (circle) Male / Female Age________
Home # ______________________________
Address ______________________________
____

Occupation ______________________________
Work # ______________________________
Cell # ______________________________
Email ______________________________
Emergency Contact ______________________________
Emergency Contact # ______________________________

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? ______________________________

Health Concerns (List in order of importance):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Health Care Providers:

Medical Doctor ______________________________
Phone # ______________________________
Fax # ______________________________

Dentist ______________________________
Phone # ______________________________
Fax # ______________________________

Specialist ______________________________
Phone # ______________________________
Fax # ______________________________

Specialist ______________________________
Phone # ______________________________
Fax # ______________________________

Other Health Care Providers:

Type of Provider ______________________________
Name ______________________________
Phone # ______________________________

Type of Provider ______________________________
Name ______________________________
Phone # ______________________________

Type of Provider ______________________________
Name ______________________________
Phone # ______________________________

Type of Provider ______________________________
Name ______________________________
Phone # ______________________________

Medical and Lifestyle Information:

General Information:

General state of health (circle one): excellent good fair poor
Energy level: _____ / 10 (0 – no energy, 10 – abundance of energy)
How often do you exercise? _____ / wk
What is your exercise routine? ______________________________
How many hours of sleep do you get per night? _____
Do you wake feeling rested? YES / NO
Do you wake up during the night? (circle one): YES / NO If so, how often? _____ Reason for waking? ______________________________
How often do you spend a day doing the following? Driving_____ Watching TV_____ Reading _____ On the computer _____ Working _____
Reason for your visit today? ______________________________

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Please check the following that apply to you:

☐ Cancer ☐ Diabetes ☐ Other major illness ☐ Depression ☐ Alcoholism
☐ High blood pressure ☐ Seizures ☐ Venereal disease ☐ Asthma ☐ HIV
☐ Low blood pressure ☐ Hepatitis ☐ Arthritis ☐ Allergies ☐ Other: ______________
☐ Heart disease ☐ Thyroid Disease

☐ Surgeries (please list dates and details): ____
____
____
____

☐ Significant trauma (falls, auto accidents, other): ____
____
____
____

Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities

Allergy / Sensitivity	Severity of reactions

Medications/Supplements: Please list all current medications/supplements/homeopathics and over-the-counter medications

Medication/Supplement	Dose/Length of use	Condition it is treating

Do you use any of the following? (please check each one that applies to you):

Substance	✔	How often / How long / How much / How many / What Brand / Type
Alcohol		
Artificial sweeteners		
Cigarettes		
Coffee		
Cravings		
Pain relief medication		
Pop		
Recreation Drugs		
Salt		
Sugar		
Tea		
Other		

Check off any of the following if they are a CURRENT or RECURRING symptom:

Skin and Hair:

☐ Rashes ☐ Itching ☐ Loss of hair ☐ Recent moles ☐ Excessive sweating
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Dry skin ☐ Night Sweating
☐ Hives ☐ Easy bruising ☐ Ulcerations ☐ No sweating ☐ Other: ______________

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Check off any of the following if they are a CURRENT or RECURRING symptom (continued):

Head and Neck:

☐ Headaches ☐ Dizziness ☐ Swollen glands ☐ Concussions
☐ Migraines ☐ Fainting ☐ Stiff neck ☐ Other: _______________

Ears:

☐ Ringing ☐ Earache ☐ Poor hearing ☐ Vertigo ☐ Other: _______________

Eyes:

☐ Blurry vision ☐ Glasses/Contacts ☐ Cataracts ☐ Poor night vision
☐ Eye strain ☐ Eye pain ☐ Spots/floaters ☐ Other: _______________

Nose, Throat, Mouth:

☐ Sinus problems ☐ Dry nose ☐ Excessive thirst ☐ Grinding teeth ☐ Other: _______________
☐ Mouth/tongue ulcers ☐ Nose bleeds ☐ Dry mouth ☐ TMJ
☐ Difficulty swallowing ☐ Facial pain ☐ Jaw clicks ☐ Frequent sore throat

Respiratory:

☐ Difficulty breathing ☐ Wheezing ☐ Coughing blood ☐ Pain with a deep breath ☐ Shortness of Breath
☐ Chronic Cough ☐ Asthma ☐ Tight Chest ☐ Production of phlegm ☐ Difficulty breathing lying down
☐ Other

Cardiovascular:

☐ High blood pressure ☐ Palpitations ☐ Chest pain/tightness ☐ Blood clots ☐ Swollen hands/feet/ankles
☐ Low blood pressure ☐ Anemia ☐ Poor circulation ☐ Cold hands/feet ☐ Bruise easily ___________
☐ Irregular heartbeat ☐ Sciatica ☐ Tremors ☐ Chills/fever ☐ Other:_________________

Gastrointestinal:

☐ Indigestion ☐ Constipation ☐ Vomiting ☐ Rectal pain ☐ Blood in stool
☐ Gas ☐ Nausea ☐ Laxative use ☐ Hemorrhoids ☐ Diarrhea
☐ Bad breath ☐ Stomach pain ☐ Hiccups ☐ Acid regurgitation ☐ Bloating
☐ Mucous in stool ☐ Poor appetite ☐ Excessive hunger ☐ Weight loss/gain ☐ Other:_________________
☐ Peculiar tastes/smells bothersome

Urinary:

☐ Incomplete urination ☐ Pain on urination ☐ Kidney stones ☐ Cloudy urinate ☐ Wake at night to urinate
☐ Uncontrolled bladder ☐ Frequent urination ☐ Bedwetting ☐ Blood in urine ☐ Other:_________________

Gentio:

☐ Pain/itching of genitals ☐ Nocturnal emission ☐ Impotence ☐ Premature ejaculation ☐ Increased/decreased libido
☐ Other:_________________

Musculoskeletal:

☐ Neck pain ☐ Hand/wrist pain ☐ Knee pain ☐ Hip Pain ☐ Localized weakness
☐ Upper back pain ☐ Shoulder pain ☐ Foot/ankle pain ☐ Joint pain/disorder ☐ Limited range of motion
☐ Lower back pain ☐ Other:_________________

Sleep:

☐ Poor sleep ☐ Insomnia ☐ Dreaming ☐ Dream disturbed ☐ Unrested upon waking
☐ Night sweats ☐ Other:_________________

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Check off any of the following if they are a CURRENT or RECURRING symptom (continued):

Neuropsychological:

☐ Poor long term memory ☐ Irritability ☐ Depression ☐ Bad temper ☐ Poor coordination
☐ Poor short term memory ☐ Anxiety ☐ Mood swings ☐ Stressed out ☐ Poor balance
☐ Areas of numbness ☐ Fatigue ☐ Seizures ☐ Tremors
☐ Sudden energy drop (time of day) ________
☐ Have you ever been treated for emotional problems?: ____
☐ Have you ever considered or attempted suicide?: ____
☐ Other neurological or psychological problems?: ____

Gynecology and Pregnancy:

Are you pregnant? (Please circle): Yes / No What is the first day of your last period? ______________________
Age of first period: ______________________ Length of cycle?: ______________________ #of days bleeding: _________________
Colour of period? (circle): Dull red dark red Purple Brown
Do you use birth control? If yes, what type? ____
Do you have changes in your body or emotions prior to menstruation? If yes please describe. ______________________
____

☐ Clots ☐ Hormone imbalance ☐ Breast lumps ☐ Heavy flow ☐ Births #________________
☐ Irregular periods ☐ Vaginal discharge ☐ Menstrual cramps ☐ Light flow ☐ Miscarriages # __________
☐ PMS – before/during/after ☐ Pregnancies # ☐ Abortions #_____________
☐ Other menstrual related pain?: ____
☐ Changes in body/psyche prior to or during menstruation/PMS symptoms, please list: ______________________
____