URGENTCARE CHIROPRACTIC®

ACUPUNCTURE PATIENT INFORMATION FORM

LAST NAME:_____ FIRST NAME_____

ADDRESS_____

CITY_____ POSTAL CODE_____

TELEPHONE: HOME_____WORK_____CELL_____

SEX: MALE ☐ FEMALE ☐ DATE OF BIRTH: M_____D_____Y_____ AGE:_____

OCCUPATION:_____ HEALTH CARE # _____

EMAIL ADDRESS (OPTIONAL)_____

PHYSICIAN'S NAME, ADDRESS & PHONE NUMBER_____

_____

Is this a workplace injury? Yes / No *Please be advised that we do not accept WCB cases.

Is your injury the result of a motor vehicle accident? Yes / No. If yes, additional intake forms are required.

Whom can we thank for your referral? We would like to send them a token of our appreciation._____

DO YOU HAVE REASON TO BELIEVE YOU MAY BE PREGNANT? YES ☐ NO ☐

STARTED DATE OF THE CURRENT SYMPTOM:_____

PREVIOUS MEDICAL VISITS FOR YOUR CURRENT SYMPTOM: ACUPUNCTURIST CHIROPRACTOR PHYSICIAN RMT

OTHER_____ (PLEASE CIRCLE)

WHAT WAS THE DIAGNOSIS OF YOUR CURRENT SYMPTOM:_____

SURGERY: YES ☐ NO ☐ WHEN/WHERE:_____

WHEN/WHERE:_____

ARE YOU TAKING MEDICATION? YES ☐ NO ☐ MEDICATION NAME:_____

MEDICATION NAME:_____

FEES include the GST

Initial Consultation: $ 113 Regular Office Visit: $ 93 Missed Office Visit: $62 (<24 hours' notice)

In consideration of your practitioner and fellow patients, 24 hour notice of change of appointment or cancellation must be given or a fee will be charged. _____ (initial)

SIGNATURE:_____ DATE:_____

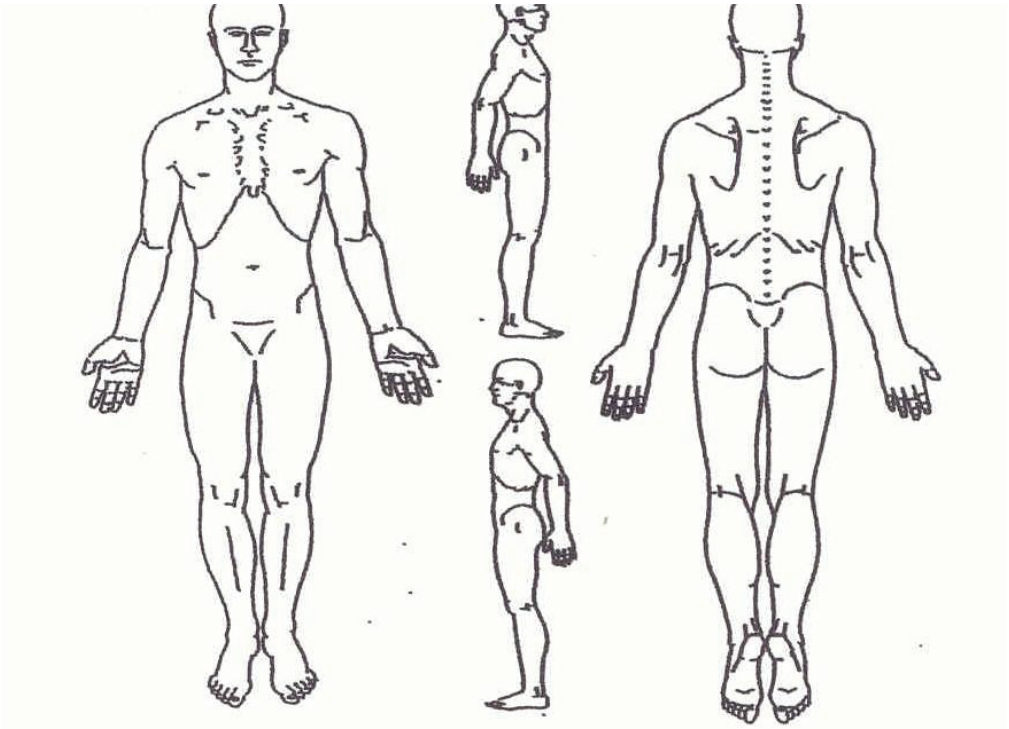
Using the line scale provided below: Rate the pain you are experiencing NOW!

No Pain 0====1======2======3======4=====5======6======7======8======9======10 Severe Pain

DRAWING OF AREA(S) OF CONCERN

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas

Pain area(s)	Ache	Numbness	Pins and Needles	Burning	Stabbing
	\\\\\	++++++	oooooooo	bbbbb	sssss
	\\\\\	++++++	oooooooo	bbbbb	sssss



MAJOR COMPLAINT:

_____

_____

_____

_____

WHAT RELIEVES THE PAIN?_____

_____

WHAT AGGREVATES THE PAIN?_____

_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. **Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have read this form and discussed with the chiropractor the assessment of my condition and the treatment plan. I Understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date