File:_____

Betty's Acupuncture & Wellness Center

Patient Information:

Full Name: _____ **Date of Birth:** _____ **Sex:** _____

Home Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____

Emergency Contact Information:

Name: _____ **Relationship to Patient:** _____

Phone Number:_____

Medical History:

Allergies: _____

_____

Family Health History (e.g. cancer, heart disease, diabetes, high blood pressure):

_____

_____

Do you smoke or drink alcohol? **Yes:** _____ **No:** _____

If yes, for how long and how often? **Smoking:** _____

Alcohol: _____

Do you use recreational drugs? **Yes:**____ **No:**_____

If yes, please list the drug(s) and frequency of use:

_____

File:_____

Current Diagnosis & Health Conditions (please check all that apply):

[ ] Asthma	**[ ] Diabetes**	**[ ] Cancer**
[ ] High Cholesterol	**[ ] High Blood Pressure**	**[ ] Arthritis**
[ ] Heart Attack/Stroke	**[ ] Osteoporosis**	**[ ] Hepatitis (A/B/C)**
[ ] HIV/AIDS		

[ ] Other (please specify):_____

Are you currently undergoing treatment from other healthcare providers? If so, please list the treatments below: _____

_____

Are you taking any medication (prescriptions, over-the-counter, herbal etc)? If so, please list below: _____

_____

Other health concerns that we should be aware of (e.g. recent surgeries or hospital stays, past motor vehicle accidents with lingering effects, sports injuries etc.):

_____

_____

Are you pregnant? Yes:____ No:____ Unsure:____ N/A:_____

Reason(s) for visit: _____

_____

_____

How did find or hear about Betty's Acupuncture and Wellness Center?

_____

Pulse: _____(for practitioner) **Tongue:** _____(for practitioner)

File:_____

According to your current health condition, we may use one or several of the following treatments to help you:

Acupuncture	**Drops of Blood Release**	**Seven-star Needles**
Needles	**Tuina Massage**	**Chinese Herbal Medicine**
Auricular Points	**Cupping**	**Guasha**

The following reactions may occur:

- Some patients may feel slightly drowsy after treatment although most patients are still able to operate a vehicle. However, we recommend that the patient remain in the clinic until they feel completely focused or arrange other methods of transportation.
- Cupping will cause bruising or swelling. The swelling typically goes down within a day. Bruising will usually disappear within one week; some individuals may require more than a week. During the procedure, cupping will cause some minor pain/discomfort in the first few minutes which generally subsides completely. Bruises resulting from cupping may be slightly tender for the first couple of days but will usually not cause extended discomfort.
- Some patients (in rare cases) may feel more pain after Chinese Tuina massage upon the first visit. This will usually subside with further treatments.
- After Blood Release or Seven-star Needles treatment, there will be some small spots of bruising or some superficial pain. Minor, non-permanent scarring may also occur.
- Some individuals may get diarrhea after taking certain Chinese herbal medicine (with the exception of elimination herbal medicines which are expected to cause diarrhea). This is a normal reaction from the body trying to self-adjust during the first or second day after consumption.

IMPORTANT NOTE:

- Please let us know prior to treatment if you are in a hungry state.
  It is strongly recommended that you have eaten before commencing treatment. Low blood sugar levels may cause unwanted side effects during treatment such as headache, dizziness, light-headedness and/or fainting.
- Please also let us know prior to treatment if you have a fear of needles. Certain treatments make use of needles and it is important that the practitioner is aware in case any unwanted side effects occur (e.g. light-headedness, dizziness, fainting).

Patient Informed Consent:

I hereby state that I have spoken with my Traditional Chinese Medicine practitioner about the details of my treatment and assessment and am aware of the following:

- Certain treatments of Traditional Chinese Medicine may include the use of single-use sterile needles to penetrate the skin.
- I understand that adverse side effects of treatments may occur (usually temporary) and are not limited to: minor pain, soreness, drowsiness, light-headedness, bleeding, discolouration, bruising,

nausea as well as other unforeseen risks. While undergoing the treatment, minor pain/discomfort and minor bleeding may also be experienced. I accept the risks involved with my treatment.

- I understand that in the case of prescribed herbal medicine, if I agree to take the medicines, I must adhere to the given directions for dosage and administration. The practitioner is not responsible for patient misuse.
- Use of Traditional Chinese Herbal Medicine is generally very safe but may cause adverse side effects such as diarrhea, nausea and other unforeseen effects.
- I should inform my practitioner as soon as possible of any lasting effects or unusually strong reactions resulting from Traditional Chinese Medicine treatments (e.g. notable bruising or soreness for more than a week, persistent diarrhea after taking herbal medication). The practitioner will assess the situation and judge whether treatment should continue, be altered, or halted.
- I must inform my practitioner if I currently have or develop any notable health issues (e.g. hemophilia).
- I must inform my practitioner if I have any infectious diseases or carry any infectious agents (e.g. HIV, Hepatitis). I understand that my practitioner has the right to refuse treatment if the risk of cross-infection is deemed too great.
- I understand that no results are guaranteed and that Traditional Chinese Medicine treatments are not a miracle cure.
- I understand that in certain cases, my symptoms may temporarily worsen before they improve.
- I am responsible for full payment at the end of each appointment.
- I understand that 24 hour notice is required for any appointment cancellations and I will be responsible for any cancellation fees incurred.
- I understand that a record of my treatments and any personal information I provide will be kept on file for use within the clinic. This information will be kept confidential and will not be released to third-parties unless permission is granted by me or required by the law.

I also hereby state that I have had the opportunity to ask any questions I may have and understand the reasons and risks for the procedure to be administered to me and voluntarily give my consent. I may also withdraw my consent at any point during the treatment and end my participation at any time.

In addition, I give my permission for this consent form to cover the entire duration of my treatment and any future treatments I may receive at this clinic.

If you have fully read and understood the information above and consent to take the treatment plan from the practitioner, please sign your name below (if patient is a minor or cannot consent for himself/herself, the legal guardian may sign instead). Thank you.

Patient or Guardian Signature: _____

Printed Patient Name:_____

Printed Name of Guardian (if applicable):_____

Date: _____