Aram Masee Chinese Medicine

Acupuncture Patient Intake Form

Name: _____ Date: _____ Gender: _____

Address: _____ Birthdate: _____

_____ Occupation: _____

Phone: _____ Emergency Contact: _____

Email: _____ _____

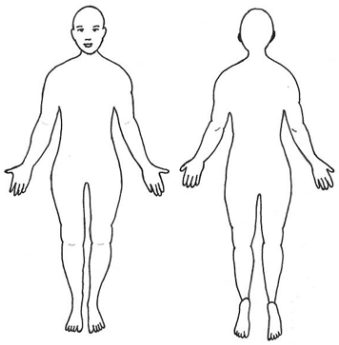
Family Doctor:_____ Personal Health Number: _____

Have you had acupuncture before?_____

What brings you into the clinic today?_____

_____

Please show the areas of greatest discomfort on the diagram and describe them:



_____

_____

_____

_____

_____

_____

Please list any major accidents, injuries or surgeries, with dates:_____

_____

Do you have any of the following: ☐Allergies:_____ ☐Asthma ☐Cancer ☐Diabetes ☐Emotional Disorder ☐Heart Disease ☐Hepatitis ☐High Blood Pressure ☐Infectious Disease ☐Rheumatic Fever ☐Seizures ☐Sleep Disorder ☐Tuberculosis ☐Other: _____

Please list any major illnesses in your family: _____

_____

Are you currently on any medication? Please list:_____

_____

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Agreements

All medical and personal information provided by the patient is kept confidential and the acupuncture clinic adheres to Canadian patient privacy laws.

If the patient needs to cancel, the acupuncture clinic requires at least 24 hours notice, or the patient will pay the full fee for the missed treatment.

Cautions and Disclosure

I, _____ hereby request and consent to acupuncture treatment(s) and other procedures and modalities associated with Chinese Medicine by Aram Masee, TCMP. I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal prescription, cupping, electro-acupuncture stimulation, moxibustion heat therapy and dietary and lifestyle counselling. I understand that the diagnosis given to me conforms to the principles of Chinese Medicine and in no way purports to replace western medical evaluation, diagnosis or treatment.

I have provided a full history and description of complaints and a health status which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary. I understand that no guarantee has been made concerning the use and effects of acupuncture and Chinese Medicine. I understand that I may refuse treatment at any time. I will notify Aram Masee, TCMP if I am, or become, pregnant.

I have been informed that acupuncture is a generally safe method of treatment that utilizes sterile needles and is done in a clean, safe environment. As with all medical procedures, acupuncture and related modalities may have side effects including: bruising, numbness or tingling, minor bleeding, broken needle, dizziness and fainting, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. Some very rare risks of acupuncture include pneumothorax and infection. Burns and/or scarring are a potential risk of indirect moxibustion heat therapy. I am advised to seek medical care for adverse effects ie. vomiting, fainting, bleeding, dizziness, severe headache etc., should they occur after treatment.

By signing below I show that I have read this consent to treatment and understand the risks and benefits of acupuncture and other procedures, and I voluntarily give my consent to Aram Masee, TCMP to proceed with his initial diagnosis and treatment. I understand that hereafter, verbal consent will be sought for all therapies and treatments in clinic, and it will be noted in my file when required.

Dated:_____ Signature of patient: _____