

Patient Information and Consent Form

Please read the following carefully. If there is anything you do not understand, please ask.

What is Acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. When indicated, additional methods of treatment such as the use of electrical stimulation of needles, Tui Na Massage, moxibustion, cupping (application of suction to the acupuncture points), and gua sha (skin scraping) may be used during treatment.

Is Acupuncture Safe?

You need to be aware that:

Drowsiness occurs after treatment in a small number of patients

Minor bleeding or bruising occurs after acupuncture in about 3% of treatments

Pain during treatment occurs in about 1% of treatments

Symptoms may get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign.

Lightheadedness may occur in new patients, due to hunger, extreme fatigue, or nervousness.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

If you have ever experienced fainting or seizures

If you have a pace maker or any other electrical implants

If you have a bleeding disorder

If you are taking anti-coagulants (blood thinners) or any other medication

If you have a heart condition, diabetes, high blood pressure, HIV, hepatitis, or any other risk of infection

If you are pregnant, suspect you may be pregnant, or are attempting to conceive

Single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information. By signing this form, I consent to receive acupuncture treatment and such additional methods of Chinese Medicine treatment as may be agreed to, including laser and auricular retention needles, between myself and Corinna McFarlane and/or Jeff McMackin. I understand that I can refuse treatment at any time.

Signature:

Date:

Print name in full:

Practitioner:

Patient Information

Confidential

Corinna McFarlane, Jeff McMackin: Practitioners of Oriental medicine Phone: 705-444-8555 www.bluemtnacupuncture.com

Please take a moment to provide some information about yourself and your health conditions so that I may do my best to treat you. This information is privileged practitioner/client communication and will be held in confidence.

Name: _____ Date: _____
Age: _____ Date of Birth: *DD/MM/YY* Sex: M F Marital Status: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ Occupation: _____
Family Physician: _____ Phone: _____
How did you find out about us? _____ Have you tried acupuncture before? _____
Contact in case of emergency: _____ Phone: _____

Medical History

What is your major complaint or condition you want to improve? _____

What have you done to get relief? _____

Have you seen your family doctor for this condition? Y N Specialist? _____

Have you received a medical diagnosis? Y N _____

Are you now under medical or other therapeutic treatment? Y N _____

Significant Illnesses (please check all that apply):

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Aneurysms | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |

Allergies: _____

List any medications that you are presently taking: (include past 6 months)

Medication	Strength	How many per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any surgeries you have had: _____

Significant trauma (auto accidents, falls, etc.) _____

What are your expectations of acupuncture treatments? _____

Check off what you have experienced over the past 6 months.

General

- | | | | |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Sweat spontaneously | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lack of sweating | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Aversion to cold | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night Sweating | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Aversion to heat | <input type="checkbox"/> Numbness | <input type="checkbox"/> insomnia | <input type="checkbox"/> Weight Gain |

Head and Neck

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nasal obstruction | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Phlegm in throat | <input type="checkbox"/> Dry/burning eyes |
| <input type="checkbox"/> Heaviness in head | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Sores on tongue | <input type="checkbox"/> Eye pain/strain |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> TMJ/jaw pain | <input type="checkbox"/> Taste change | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Hearing Loss |

Musculo-Skeletal

Pain, weakness or numbness in:

- | | | | |
|------------------------------------|---------------------------------|--|--|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Hips | <input type="checkbox"/> Knee problems | <input type="checkbox"/> Spasms/cramps |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Legs | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Feet | <input type="checkbox"/> Pain all over | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Joints | <input type="checkbox"/> All over weakness | <input type="checkbox"/> Osteoporosis |
| | | <input type="checkbox"/> Lack of Strength | <input type="checkbox"/> Scoliosis |

Cardiovascular

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Varicose Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Phlegm production |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Rib side pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty inhaling |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Distention in chest | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Difficulty exhaling |

Neurologic

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Tremor | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Stroke | <input type="checkbox"/> Recent Clumsiness | <input type="checkbox"/> Twitching of face |
| <input type="checkbox"/> Handwriting change | <input type="checkbox"/> Seizure/Epilepsy | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Spinal cord injury |

Gastrointestinal

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Diarrhea/loose stools | <input type="checkbox"/> Black stools | <input type="checkbox"/> Vomiting Blood |
| <input type="checkbox"/> Gas | <input type="checkbox"/> IBS | <input type="checkbox"/> Difficulty swallowing | Other: |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Heartburn/reflux | |

Genitourinary

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Dilute urine | <input type="checkbox"/> cloudy urine | <input type="checkbox"/> Scanty urine | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Dark urine | <input type="checkbox"/> Burning urination | <input type="checkbox"/> Profuse urine | <input type="checkbox"/> Nighttime urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Poor bladder control | <input type="checkbox"/> Recurrent UTI's |

Emotional

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Often feel angry | <input type="checkbox"/> Eat a lot of sweets | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Grief/Sadness | <input type="checkbox"/> Mind not clear | <input type="checkbox"/> Eat a lot of fried foods | <input type="checkbox"/> Exercise in excess |
| <input type="checkbox"/> Worry/Overthinking | <input type="checkbox"/> Poor memory | <input type="checkbox"/> High caffeine intake | <input type="checkbox"/> Shift work |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Eating Disorder | |