Acupuncture Intake

Name _____ Sex M F Date_____

Care Card # _____ Date of Birth (mm/dd/yyyy)_____ Age_____

Address _____City_____ Province _____ Postal Code_____

Home Phone _____Work Phone _____ Cell Phone_____

Would you like appointment reminders? → □ Email _____ □ Text □ No reminders

Medical Doctor_____ Occupation _____ Employer_____

Who referred you to this clinic? Google/Drove By/Friend/Fix Healthcare Sign/Other_____

Please circle your insurance company below if you would like us to direct bill them.

Plan #_____ Id # _____Primary's full name (if not you) _____

Primary's birthdate (mm/dd/yyyy) _____ Primary's Plan # _____ Primary's Id # _____

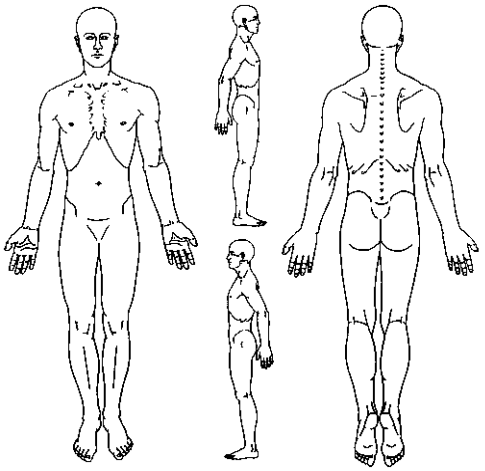
Have you ever received Acupuncture? Yes No

Reasons for seeking Acupuncture & Chinese Medicine:

Primary Reason: _____

Secondary Reason: _____

Location of Complaint: Use drawings ---------->



A = ACHE	**C= CRAMPS**
P = PINS & NEEDLES/ TINGLING	**ST= STIFFNESS**
B = BURNING	**S = STABBING/SHOOTING**
N = NUMBNESS	**O = OTHER**

Complaint began when & how? _____

Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Does anything aggravate this condition? _____

Does anything relieve this condition? _____

Does this condition interfere with: (circle) Work Daily Routine Exercise Sleep

Rate the following 1(poor) to 5 (excellent): _____ Sleep Patterns _____ Eating Habits _____ Exercise Habits _____ Water Consumption

What treatments have you tried? (circle) Chiropractic Medical Doctor Massage Therapy Physiotherapist Naturopath Other _____

fix
HEALTHCARE

INFORMED CONSENT FOR ACUPUNCTURE TREATMENTS

I hereby request and voluntarily consent to receive treatments of acupuncture and Chinese Medicine procedures for my present and future health conditions. I understand that treatment will be administered by Registered Acupuncturists (R. Ac.) **Claire Lipke, or Ian Abbott.**

Acupuncture treatments that may be administered:

Acupuncture: A treatment involving the insertion of thin sterile disposable needles through the skin, which can produce a mild but temporary discomfort at the acupuncture site. It can occasionally cause slight bleeding and will rarely leave a bruise. Other possible risks from acupuncture include dizziness and fainting. The patient should report to the R.Ac any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) including nerve damage, organ puncture and infection.

Cupping: A localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Extremely rare is a slight burn or blister due to the heat.

Tui-Na: A Chinese Massage technique that uses pressing, rubbing, kneading and pinching to bring the body back into balance. Tui-Na is applied to channels, collaterals and acupuncture points. Manipulating the body using Tui-Na locally promotes blood accumulation and removes blood stasis.

Heat Treatment with a TDP lamp: A warming method using an infrared heat lamp on a specific area of the body. Every precaution is taken to prevent over warming, but the rare possibility of mild burns exist.

Electrostimulation: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of treatments under Chinese Medicine. I understand that results are not guaranteed. I understand that only sterile disposable needles will be used during my treatments. All acupuncture needles will be properly disposed of after each and every treatment. I further understand and am informed that the practice of acupuncture poses slight risks from treatment, including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time based upon the facts then known in the best of my interests.

By signing below I show that I have read the information on this consent form. I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Registered Acupuncturist. I understand that I can request more information at any time if desired. I consent to receive treatment that involves the above procedures. I understand that I have the right to refuse or discontinue treatment at any time. I understand that this refusal may affect the expected results.

In consideration of other patients and other practitioners, a minimum of 24 hours' notice is required to change or cancel appointments. This time has been reserved for you and unattended appointments prevent practitioners from seeing other patients. Patients will be expected to cover the full treatment fee in the case of missed appointments or late cancellations that cannot be booked by another patient. Please be advised that non-attended appointments cannot be billed to insurance providers. Thank you for your consideration.

If I am using my extended benefits, I authorize Fix Healthcare to direct bill on my behalf and receive payment for my treatments directly. I agree that I will be responsible for any fees which are not covered by my insurance, including those which may be initially accepted but later refused by my insurance.

_____	_____	_____	_____
Print Patient Name	Signature of Patient (or guardian)	Date	Signer for Fix Healthcare

Assignment of Medical Services Plan Benefits to Opted-Out Practitioner

I, _____ (beneficiary) authorize the Medical Services Plan to pay my Practitioner directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for the patient portion of the fee and the amount that is reimbursable by the Medical Services Plan ($23.00). The amount reimbursed by MSP will be directed to the Practitioner checked above and be applied against any outstanding monies I owe for services provided. This form allows the practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Our practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreements, your practitioner may not charge you the portion reimbursable by MSP.

I understand that any appointments I receive over and above the 10 subsidized treatments per year will be my responsibility to pay at the private fee rates.

Patient's Name: _____ (please print) Care Card Number (PHN): _____

Signature:_____ Date:_____

MEDICAL HISTORY

Please check any of the following that have ever affected you and indicate date

□ Addiction_____	□ Candida	□ Fibromyalgia	□ Kidney Stones	□ Seizures
□ AIDS	□ Chicken Pox	□ Gall Stones	□ Malaria	□ Stroke
□ Alcoholism	□ Chronic Fatigue	□ Glaucoma	□ Measles	□ STD_____
□ Anemia	□ Colitis/IBS	□ Goiter	□ Meningitis	□ Thyroid Problems
□ Appendicitis	□ Diabetes	□ Gout	□ Mononucleosis	□ Tonsillitis
□ Arteriosclerosis	□ Digestive Disorders	□ Heart Disease	□ Multiple Sclerosis	□ Tuberculosis
□ Arthritis	□ Eating Disorder	□ Hernia	□ Mumps	□ Typhoid Fever
□ Asthma	□ Hepatitis	□ Nephritis	□ Ulcers	□ Elevated Liver Enzymes
□ Breast Lumps	□ Emotional Imbalance	□ Herpes	□ Neuralgia	□ Urinary Problems
□ Breathing Problems	□ Emphysema	□ High Cholesterol	□ Paralysis	□ Whooping Cough
□ Bronchitis	□ Epilepsy	□ Hypertension	□ Prostate Problems	□ Bursitis
□ Cancer	□ Hypotension	□ Rheumatism	□ Scarlet Fever	□ Other: _____
□ HIV Positive	□ Food, Chemical Poisoning			

Surgeries, Hospitalizations and Significant Trauma's (auto accidents, falls, loss of loved ones, etc).

Date	Event
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

_____

_____

_____

_____

Chinese Medicine – Symptomology

Please mark the following symptoms that you currently have.

General:

□ Fatigue	□ Insomnia	□ Disturbed Sleep	□ Frequent Dreams	□ Alternating Fever & Chills
□ Dislike Cold	□ Dislike Heat	□ Weight Loss	□ Weight Gain	□ Unusual Daytime Sweating
□ Chills	□ Edema or Swelling	□ Night Sweats	□ Fever	□ Other: _____
□ Usually Thirsty	□ Seldom Thirsty	□ Excessive Sleep		

Skin:

□ Rashes	□ Hives	□ Acne	□ Easily Bruised	□ Changes in Lumps/Moles
□ Unusual Bleeding	□ Other: _____			

Head & Neck:

□ Dizziness □ Jaw Pain □ Other: _____ □ Headaches: _____

Eyes & Ears:

□ Failing Vision □ Blurred Vision □ Visual Spots □ Night Blindness □ Eye Pain/Swelling
□ Ringing in the Ears □ Ear Pain □ Ear Discharge □ Other: _____

Nose/Throat/Mouth:

□ Nose Bleeds □ Sore throat □ Hoarseness □ Tooth or Gum Pain □ Nasal Discharge/Infection
□ Frequent Sneezing □ Bleeding Gums □ Other: _____ □ Difficulty Swallowing □ Change in sense of taste
□ Change in Sense of Smell □ Mouth/Tongue Ulcers

Muscles & Joints - Pain, weakness or numbness in:

□ Hips/Leg/Feet □ Hot Joints □ Body Pain □ Muscle Cramps □Neck/Shoulder/Arm/Head
□ Swollen Joints □ Heavy Limbs □ Other: _____ □ Sore Low Back & Knees

Nervous Systems:

□ Fainting □ Paralysis □ Tremors □ Poor Balance □ Seizures
□ Other: _____

Heart, Lungs & Chest:

□ Palpitations □ Chest Pain □ Tightness □ Rapid Heart Beat □ Irregular Heart Beats
□ Cough □ Dry Cough □ Frequent Colds □ Asthma/Wheezing □ Swelling of the ankles
□ Coughing up Blood □ Shortness of Breath □ Coughing up Phlegm □ Pain in Rib Cage □ Other: _____

Mental/Emotional:

□ Poor Memory □ Worry □ Anxiety □ Depression □ Difficulty Concentrating
□ Frustration or Anger □ Fearfulness □ Stress □ Irritability □ Other: _____

Digestive System:

□ Nausea □ Diarrhea □ Loose Stool □ Hemorrhoids □ Vomiting Food
□ Constipation □ Stomach Pain □ Bloody/Black Stool □ Vomiting Blood □ Other: _____

Urinary/Genital:

□ Incontinence □ Painful Urination □ Difficult Urination □ Cloudy Urine □ Frequent Daytime Urination
□ Bloody Urine □ Genital Pain/Itch □ Low Sexual Drive □ Excessive Sexual Drive □ Frequent Night Urination
□ Genital Discharge (Lesions) □ Painful Intercourse □ Other: _____

Male:

□ Impotence □ Weak Urinary Stream □ Prostate Hypertrophy □ Premature Ejaculation □ Seminal Emissions
□ Other: _____

Female:

□ Irregular Periods □ Painful Periods □ No Periods □ Scanty Periods □ Menopausal Symptoms
□ Passing Clots □ PMS □ Breast Lump □ Early Periods □ Breast Pain & Discharge
□ Abnormal PAP smear □ Bleeding Between Periods □ Other: _____

Hospitalizations: (Please note if you have ever been hospitalized and why)

_____

_____

_____

_____

_____

Medications:

NAME	DOSAGE

Supplements:

NAME	DOSAGE

Health Habits:

Substance	x	How much do you use or consume how often
Sugar		
Caffeine		
Tobacco		
Alcohol		
Recreational Drugs		
Other		

Diet: Describe your diet in general terms. Number of meals per day, how often you eat out, dietary restrictions, favorite flavors & foods.

_____
_____
_____
_____

Do you exercise regularly? **Yes** □ **No** □
Describe:

_____
_____
_____
_____

_____ _____ _____
Patient Name (Please Print) Patient Signature Date