PHYSIOLOGIX HEALTH SERVICES

# ACUPUNCTURE INTAKE FORM

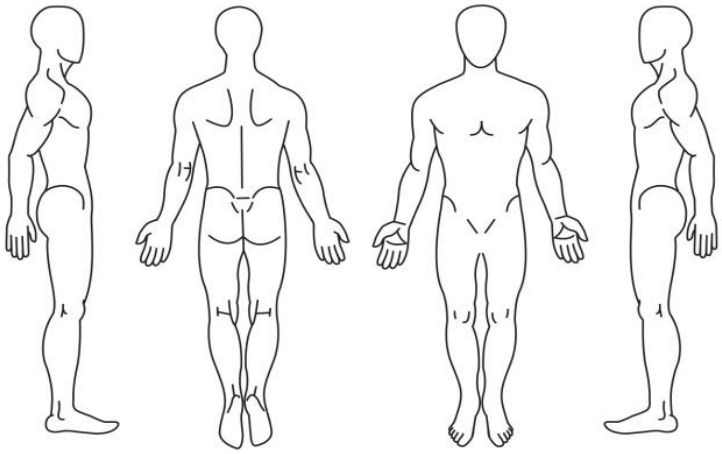
All information requested will assist in treating you safely. All information provided is kept confidential & private unless we have your signed consent or as required by law.

| | |
|---|---|
| Name: | Provincial Healthcare #: |
| Date of Birth: dd / mm / yyyy | Phone: |
| Address: | City & Postal Code: |
| Email: | Emergency Contact: Name & Number |
| Occupation: | Referral method: |

Are you here due to a Motor Vehicle Accident? ☐ No ☐ Yes Claim # & Date of Loss

Are you here due to a WCB claim? ☐ No ☐ Yes Claim # & Date of Loss

1) Have you ever had acupuncture before? ☐ No ☐ Yes
2) Please let us know the top 2 reasons why you are seeking acupuncture: _____
3) Have you sought help from other fields of practice? ☐ No ☐ Yes
   ☐ Massage Therapist ☐ Chiropractor ☐ Medical Physician ☐ Physical Therapist ☐ Other
4) Please circle the areas you would like us to focus on:



**INDICATE YOUR SYMPTOMS:**

☐ Dull Ache
☐ Numbness
☐ Pins & Needles
☐ Sharp Pains
☐ Soreness
☐ Tension

**HAVE YOU HAD SURGERY?**

☐ No ☐ Yes

**ARE YOU PREGNANT?**

☐ No ☐ Yes

5) What aggravates your symptoms? _____
6) List all known allergies: _____
7) List current medications: _____
8) List any previous injuries: _____

## PLEASE CHECK OFF ANY APPLICABLE MEDICAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| ***Cardiovascular***:<br>☐ Low Blood Pressure<br>☐ High Blood Pressure<br>☐ Heart Attack<br>☐ Heart Disease<br>☐ Congestive Heart Failure<br>☐ Stroke/CVA<br>☐ Phlebitis/Varicose Veins<br>☐ Chest Pains | ***Respiratory:***<br>☐ Shortness of Breath<br>☐ Asthma<br>☐ Bronchitis<br>☐ Emphysema<br>☐ Chronic Cough<br>***Medical Devices:***<br>☐ Pace Maker<br>☐ VAD<br>☐ Colostomy Bag | ***Infections:***<br>☐ AIDS<br>☐ Herpes<br>☐ Hepatitis<br>☐ HIV<br>☐ Shingles<br>☐ Contagious Skin Condition | ***Other:***<br>☐ Altered Sensation<br>☐ Anemia<br>☐ Arthritis<br>☐ Bleeding Disorder<br>☐ Blood Clots<br>☐ Blurred Vision<br>☐ Cancer<br>☐ Crohn's Disease | ☐ Disc Herniation<br>☐ Dizziness<br>☐ Double Vision<br>☐ Eczema<br>☐ Epilepsy<br>☐ Gastrointestinal Problems<br>☐ Hearing loss<br>☐ Indigestion<br>☐ Insomnia<br>☐ Joint Pain | ☐ Limitation of movement<br>☐ Migraines<br>☐ Multiple Sclerosis<br>☐ Nausea<br>☐ Osteoporosis<br>☐ Pinched Nerve(s)<br>☐ Psoriasis<br>☐ Spinal Injury<br>☐ Tinnitus<br>☐ Fibromyalgia |

**Other conditions not listed above**: _____

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# ACUPUNCTURE INTAKE FORM

## Acupuncture Information & Risks

Acupuncture involves the insertion of exceptionally fine needles at strategic points on your body. It is a safe and natural form of healing. Forms of treatment may include acupuncture, cupping, electrical stimulation, moxibustion, acupressure in combination with acupuncture or any other techniques within the scope of practice of a registered acupuncturist.

Generally, the risks of acupuncture are low, some common side effects are soreness, minor bleeding or bruising where needles are inserted. Although uncommon, there is potential of swelling, tingling, and numbness. These symptoms may last a few days.

Rare/unusual risks of acupuncture include dizziness, nausea, fainting, shock, possible aggravation of existing symptoms prior to treatment and nerve damage. There may be a possibility of infection, although the therapist uses sterile-single-use needles that are disposed after use. Moxibustion and cupping may cause bruising or blistering. It is advised to avoid large movement during this type of treatment. You may be asked to remove articles of clothing in order to access specific areas of the body.

## Cancellation Policy

All Registered Therapists at PhysioLogix PT run their own practice & receive compensation solely from the services provided to their patients. Your appointment time has been reserved specifically for you & no one else. In courtesy of your therapist & your fellow patients, we require 24 hours notice for any changes or cancellations to your appointment. In the absence of 24 hours notice, patients are subject to a fee of up to 40% of the cost of session booked. All "No Show" appointments are subject to the full cost of the session missed. Please note that your insurance will not cover any missed or cancelled appointment fees.

**By signing below, I have provided my full knowledge of the information requested. I have read, understand & agree that withholding or incorrect medical information may lead to contraindications & can be dangerous to my health. The therapist is not liable for any issues arising from contraindications as a result of misinformation of medical history as provided by me. I have read & agree to abide by the cancellation policy as stated above. Having read, understood and agree with the above information & risks of acupuncture, I wish to proceed with therapy.**

**Patient Name:** PRINT NAME _____ **Therapist's Name:** PRINT NAME _____

**Patient Signature:** _____ **Therapist's Signature:** _____

**Signed on:** DATE _____

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