Healthy Families
WELLNESS CENTRE

ACUPUNCTURE AND TRADITIONAL CHINESE MEDICINE

Patient Consultation Form

Date: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Marital Status: _____ Sex: Female _____ Male _____

Occupation: _____

Emergency Contact: _____

Family Physician: _____

Have you consulted with a Physician or Dentist (as appropriate) about the condition for which Acupuncture treatment is now being sought? YES _____ NO _____

FAMILY MEDICAL HISTORY

- ☐ Allergies ☐ Diabetes ☐ Asthma
- ☐ Seizures ☐ Depression ☐ Cancer
- ☐ Stroke or Heart Disease
- ☐ Alcoholism or Drug Abuse ☐ Other: _____

PERSONAL MEDICAL HISTORY

- ☐ Diabetes ☐ Hepatitis ☐ Tuberculosis ☐ Hypertension
- ☐ Cancer or Tumor ☐ Seizure Disorder ☐ Heart Disease ☐ Allergies or skin rash
- ☐ Aids or HIV Positive ☐ Other _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

- ☐ Cold or Flu ☐ Infection/Inflammation ☐ Pregnancy/ Lactation

ARE YOU WEARING ANY ELECTRONIC DEVICES? _____

(Example: cardiac pacemaker, hearing aids etc) _____

ARE YOU ON ANY MEDICATIONS? (Please List) _____

_____

_____

ATTENTION FEMALE PATIENTS: Would you like a female observer in on the treatment with you? If available

☐ YES ☐ No

IS THERE ANY HISTORY OF INJURY OR SURGERY? (Please List) _____
_____
_____

HAVE YOU EVER TRIED ACUPUNCTURE OR HERBAL MEDICINE? _____
_____

HAVE YOU TRIED ANY OTHER ALTERNATIVE HEALTH SERVICES? (Please List) _____
_____
_____

WHAT IS YOUR MAIN CONCERN TODAY? (In your own words) _____
_____
_____
_____
_____

Informed consent: I, the undersigned, understand that the treatments and related therapies are given for the purpose of relieving my pain of discomfort and helping to heal my health problems. I also understand all of the benefits and risks of these treatments as explained to me. I shall give permission for the treatments to be performed on me, and I shall take full responsibility for any possible adverse affects resulting from the treatments.

Signature _____ Date _____