HALTON Chiropractic AND WELLNESS CLINIC

250 Wyecroft Road, Suite #5
Oakville, ON L6K 3T7
Tel: 905.844.9117
Fax: 905.844.9118
www.haltonchiropractic.ca

ACUPUNCTURE

NEW PATIENT QUESTIONNAIRE

Name: _____ Date:_____
(Last) (First)

Address: _____
(Street) (City)

_____
(Province) (Postal Code)

Phone: Home (____)_____ Work (____)_____ Cell (____)_____

E-mail Address: _____

Date of birth: _____ Age: _____ Height: _____
(Day / Month / Year)

Birth Place: _____ Weight: _____

Gender: M or F (Please Circle) # of children: _____

Emergency Contact: _____ _____ (___)_____
(Name) (Relationship) (Phone)

Family physician: _____ Referred by: _____

Occupation: _____

Employer's Name: _____

Employer's Address: _____

HEALTH HISTORY

Patient Name:_____

PLEASE CHECK THE APPROPRIATE SYMPTOM IF YOU HAVE EVER EXPERIENCED IT:

HEAD & NECK

Headaches	Hearing problems	Ringing of the ears
Vertigo	Dizziness	Eye Problems
Vision Problems	Nose Problems	Temporomandibular Problems
Sinusitis	Cavities	Other Mouth Problems
Sore Throat	Neck Pain	Voice Changes

Other problems in these areas (specify):_____

CHEST/ LUNG/HEART/SKIN

Chest pain	Palpitations	Blood pressure problems
Tachycardia	Chest oppression	Excessive dreaming
Insomnia	Night sweats	Excessive or little sweating
Lung problems	Asthma	Shortness of Breath
Allergies	Skin problems	Restlessness, irritability

Other problems in these areas (specify):_____

DIGESTIVE SYSTEM & MISCELLANEOUS

Bleeding gums	Belching	Nausea, Vomiting
Heart burning	Poor appetite	Loss of taste
Bloating	Abdominal pain	Bowel movements after meals
Sleepy after meals	Gas, rumbling	Diarrhea
Constipation	Haemorrhoids	Gaining or losing weight easily
Bruising easily	Heavy legs	Varicosities

Other problems in these areas (specify):_____

GYNECOLOGICAL SYSTEM

Painful periods	Heavy periods	Irregular periods
Long periods	Absent periods	Pre-menstrual syndrome
Hot flashes	Endometriosis	Painful Intercourse
Fertility Problems	Breast Problems	Miscarriages, abortions

Other problems in these areas (specify):_____

LIVER & GALL BLADDER

Liver problems	Sweaty palms	Sweats easily
Irritated easily	Brittle nails	Bitter taste in mouth
Muscle cramps	Anxiety	Tension headaches
Slow digestion	Restlessness	Stiff joints and muscles

Other problems in these areas (specify):_____

KIDNEY/URINARY TRACT/ENDOCRINE SYSTEM /VARIOUS

Kidney stones	Kidney problems	Urinary bladder problems
Prostatitis	Frequent urination	Urinary tract infections
Incontinence	Low sexual drive	Erectile dysfunction
Feeling cold	Feeling hot	Feeling low energy
Cold hands	Cold feet	Joint pain
Weak or sore knees	Low back pain	Bone problems

Other problems in these areas (specify):_____

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Frank Chen, RMT, R.Ac., R.TCMP

Registered Massage Therapist, Acupuncturist, Traditional Chinese Medicine Doctor

Informed Consent for Acupuncture Care

PLEASE READ CAREFULLY

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping and/or electro acupuncture by the above named doctor.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complication. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. FEMALE PATIENTS

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

_____	_____	_____
Date signed	Patient name (print)	Patient Signature
_____	_____	_____
Date signed	Witness name (print)	Witness Signature