Acupuncture Intake/Health History Form

First Name: ___________________________ Last Name: ______________________________
Date of Birth: ____ m ____ d _____ y Gender: M / F Occupation: _____________________________

Significant Illness: (please circle)
Asthma, Alcoholic, Arthritis, Cancer, Diabetes, High Blood Pressure, Heart Disease, Hepatitis, HIV(+), Seizures, Significant Trauma (auto accident, falls, etc.), Thyroid Disease, Allergies,
Other: ____

Current Medication: 1. ____________________ 2. ____________________ 3. ____________________
For What Condition?: 1. ____________________ 2. ____________________ 3. ____________________

List **Major Complaints** in order of importance (reasons for visit):
1. Complaint: ____
   Duration: _________________________ Known cause/ diagnosis: ______________________________
2. Complaint: ____
   Duration: _________________________ Known cause/ diagnosis: ______________________________
3. Complaint: ____
   Duration: _________________________ Known cause/ diagnosis: ______________________________

This statement of consent pertains to the practice of "acupuncture, electro-acupuncture, cupping, moxibustion, far infrared mineral therapy, scarping, acupressure, and shiatsu/tuina massage" as performed by *Erin Chou*, R.M.T. & Acupuncturist at **Mississauga Wellness**.

Acupuncture and other traditional Chinese medicine remedies are safe and effective for the prevention and treatment of a wide range of health conditions and for the promoting of overall well-being. These practices are not intended to replace any tests, treatments or medications recommended by your physicians.

Acupuncture /TCM services are not covered by OHIP. Coverage is provided by extended healthcare plans, please check with your employee benefits.

Acupuncture /TCM remedies may cause occasional bruising, bleeding, or post needling sensation. Fainting may occur for new patients due to nervousness, hunger or extreme tiredness. During retention of needling, patient may experience normal needling sensations, such as: heavy, numb, sore, distending, tingling, radiating/shooting sensation, or ant crawling at the location of needling or along the meridian.

Patient's Signature for Consent of Treatment: _________________________ Date: ________________
Guardian's or Legal Representative's Signature for Consent of Treatment: _______________________