Absolute Health
INCORPORATED

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Please print and complete these forms and bring them with you to your initial visit. Otherwise, please arrive 20 minutes before your visit to complete them in clinic.

Informed consent for Acupuncture

Acupuncture involves the insertion of needles to at specific points in the body in accordance with Traditional Chinese Medicine to stimulate the vital force/Qi to promote balance, healing and wellbeing. Acupuncture also works on the physiological level to modify pain perception; and or alter the pain response.

Personal Information

Name: ________________________________Date of First Visit: _____________

PHN# _______________

Birth Sex: ☐M ☐F Gender Identity: ______________________

Birthdate: __________________

Address: _______________________________ City:____________________________,

Province: ________________ Postal code: ______________

Primary phone #: __________________ Secondary phone #: ____________________

If you are under 18 years of age, please list the name, relationship, and contact information of the person who is legally responsible for you:

Name: ___________________________________ *Relation:* ______________________

Phone#: ___________________________

Emergency Contact

Name: ___________________________________ *Relation:* ______________________

Phone#: ___________________________

Are any other physician(s) or healthcare practitioners treating you? If yes, please list the name(s) and phone number(s):

____PH: _____________________

____PH: _____________________

Please list your health concerns

____

____

____

Please list known allergies or sensitivities:

Foods:____

____

Medications:____

____

Environmental factors: ____

____

Chemicals:____

____

Please list all current prescription and non prescription (including birth control pills, aspirin etc.) medications with dosages:

____

____

____

Please list all current supplements with dosages if known:

____

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____

____

Please list any hospitalizations, serious injuries, and/or surgeries: (date and type):

____

____

____

Family medical history: Please check areas pertaining to blood relatives NOT including yourself, and note whether the condition is from the maternal (M) or paternal (P) side of your family:

M	P		M	P	
☐	☐	Alcoholism	☐	☐	Neurologic disorder
☐	☐	Asthma	☐	☐	Substance abuse
☐	☐	Anxiety	☐	☐	Thyroid problems
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Cancer	☐	☐	Eating disorder
☐	☐	Epilepsy	☐	☐	Diabetes

☐	☐	Hay fever/allergies	☐	☐	Liver disease
☐	☐	Heart disease/stroke	☐	☐	Mental disorders
☐	☐	High blood pressure	☐	☐	Kidney disease

Other: Please list:

Review of Systems: *Check all continuing or recurrent problems*

General

- ☐ Stress
- ☐ Fatigue
- ☐ Insomnia
- ☐ Night Sweats
- ☐ Excessive sweating
- ☐ Difficulty falling asleep
- ☐ Sleep disturbance
- ☐ Waking up many times
- ☐ Excessive dreams
- ☐ Dizziness
- ☐ Exposure to toxic chemicals

Endocrine

- ☐ Thyroid condition
- ☐ Tendency to heat
- ☐ Tendency to cold
- ☐ Cold hands and feet
- ☐ Excessive thirst
- ☐ Lack of thirst

Mental / Emotional

- ☐ Depression
- ☐ Mood Swings
- ☐ Anxiety or nervousness
- ☐ Excessive worry/overthinking
- ☐ Lump in the throat
- ☐ Lack of motivation/sense of direction
- ☐ Fearfulness
- ☐ Poor concentration
- ☐ Poor memory
- ☐ Irritability
- ☐ Anger

Neurologic

- ☐ Seizures/epilepsy
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness or tingling
- ☐ Loss of memory
- ☐ Vertigo or dizziness
- ☐ Loss of balance
- ☐ Tremors

Skin

- ☐ Rashes, Eczema, Hives
- ☐ Itching
- ☐ Easily bruised

Head

- ☐ Headaches
- ☐ Head Injury
- ☐ Migraines
- ☐ Jaw/TMJ problems

Ears

- ☐ Hearing loss
- ☐ Ringing
- ☐ Earaches or infection

Nose and Sinuses

- ☐ Frequent colds/flus or infections
- ☐ Nose Bleeds
- ☐ Hay fever/rhinitis/congestions
- ☐ Sinus problems/congestion
- ☐ Loss of smell

Eyes

- ☐ Recent change in vision
- ☐ Blurred vision
- ☐ Eye pain/strain
- ☐ Redness/itching of eyes

Mouth and Throat

- ☐ Frequent sore throat/hoarseness
- ☐ Mouths sores/gum problems
- ☐ Loss of sense of taste
- ☐ Excessive hunger
- ☐ Lack of appetite
- ☐ Distension, heaviness, bloating
- ☐ Bitter taste in morning
- ☐ Sweet taste in morning
- ☐ Sour taste in morning

Cardiovascular/Blood/Peripheral Vascular

- ☐ Angina, heart attack
- ☐ High Blood Pressure
- ☐ Low Blood pressure
- ☐ Chest pain
- ☐ Palpitations/Fluttering, irregular beat
- ☐ Poor circulation
- ☐ Easy bleeding or bruising
- ☐ Anemia
- ☐ Clots/ thrombosis/ DVT

Respiratory

- ☐ Cough
- ☐ Difficult of painful breathing
- ☐ Asthma
- ☐ Shortness of breath

Gastrointestinal

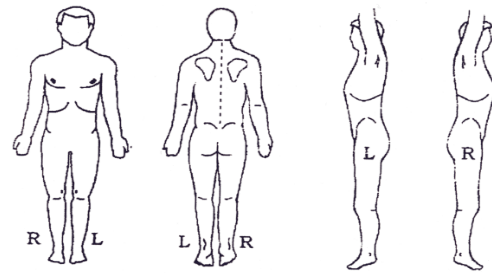
- ☐ Constipation
- ☐ Diarrhea/ loose stools
- ☐ Heartburn
- ☐ Change in thirst or appetite
- ☐ Abdominal pain or cramps
- ☐ Belching or gas/bloating
- ☐ Nausea +/- vomiting
- ☐ Blood or mucus in stool
- ☐ History of parasites

Urinary

- ☐ Pain on urination
- ☐ Excessive urination
- ☐ Frequency at night
- ☐ Inability to hold urine
- ☐ Blood in urine
- ☐ Frequent infections
- ☐ Kidney stones

Musculoskeletal

- ☐ Joint pain or stiffness
- ☐ Swollen joints
- ☐ Muscle weakness, spasms or cramps
- ☐ Mark areas you currently feel pain:



Male

- ☐ Impotence
- ☐ Lack of libido
- ☐ Difficulty in stopping or starting urination
- ☐ Decreased flow or force of urination
- ☐ Sexual difficulties
- ☐ Sexually transmitted disease

Breast (male and female)

- ☐ Self exam regularly
- ☐ Recent changes in breasts
- ☐ Breast lumps/pain/tenderness
- ☐ Discharge

Female

- ☐ Pregnant? Yes No Maybe
- ☐ Date of last PAP
- ☐ History of sexually transmitted disease
- ☐ Abnormal discharge

if pre-menopausal:

- ☐ Length of cycle: ____________ days
- ☐ Days of flow: _______________ days
- ☐ Irregular or no cycle
- ☐ Bleeding between cycles
- ☐ Painful menses
- ☐ Heavy or excessive flow
- ☐ Scanty flow
- ☐ Passing clots
- ☐ PMS
- ☐ Birth control? No Yes, type: ________________________________

if menopausal:

- ☐ Age of last menses
- ☐ Any menopausal symptoms?
- ☐ Vaginal bleeding since menopause

Potential risks associated with acupuncture treatment

Pain or discomfort at needle insertion site, bruising, numbness, weakness, nausea and fainting. Aggravation of existing problems, although uncommon may also occur. Uncommon and unlikely risks that may occur include; risk of miscarriage, nerve damage and organ puncture.

Please check off the following if you have:

- ☐ Pacemaker
- ☐ Cancer
- ☐ Artificial implants

Please check off the following if you are:

- ☐ Pregnant
- ☐ immune compromised
- ☐ on blood thinners

Statement of acknowledgement and consent

As a patient of Absolute health incorporated, I, _____________________________ ____ have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself in writing or unless law requires it.

- The information I have provided is complete, and accurate to the best of my knowledge and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.
- I have read the informed consent and am aware of potential risks associated with acupuncture

- It has been explained to me in a way that I understand, the above treatment to be undertaken, and that there are risks to the procedure or treatment proposed.

Signature: ___________________________________ Date: ________________________

I, ______________________________________, hereby consent to treatment from Dr. Cindy Tran, ND for Acupuncture, and intend this consent to cover the entire course of treatment for my present condition. I understand this consent is voluntary and may be revoked at any time.

Signature: ___________________________________***Date:*** _________________________

Cancellation policy

I understand that I am required to give a minimum of ***24 hours notice*** *if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment.*

Signature: ___________________________________Date: _________________________