Bow Valley Chiropractic

Chiropractic | Massage | Orthotics | Acupuncture

Name: _____ Date: _____/_____/_____
MM DD YYYY

Ph: (_____) _____-_____ E-mail: _____
(Optional, used for apt. reminders and direct access to Online Booking system)

Address: _____ City: _____

Postal Code: _____ Gender: _____ Birthdate: _____/_____/_____
MM DD YYYY

Medical Doctor: _____

Emergency contact: _____ PH:(_____) _____-_____

Any medications/surgeries: Y/N If YES, what? _____

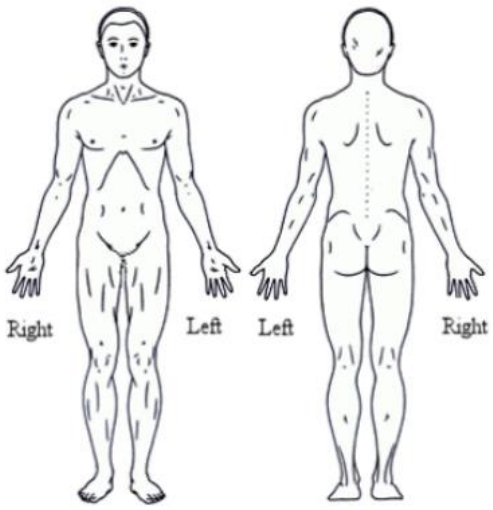
List regular physical activities: _____

Pain:

Using the symbols below, please mark on the body diagram if you have the following:

X = Pain
O = Numbness
Z = Tingling
/ = Other_____

On a scale of 1 - 10, how severe is your pain right now? _____



Do you currently have any of the following conditions?

- ☐ Pregnancy/lactation
- ☐ Cold/flu
- ☐ Infection/inflammation

Family Medical History (please check all that apply)

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Stroke/Heart Disease
- ☐ High blood pressure
- ☐ Cancer
- ☐ Seizures
- ☐ Alcoholism
- ☐ Other (please indicate)

General (please check all that apply)

- ☐ Allergies
- ☐ Birth Trauma
- ☐ Rheumatic Fever
- ☐ Accident/Trauma
- ☐ Diabetes
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Childhood Illnesses
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Seizures
- ☐ Other (please indicate)
- ☐ Hepatitis
- ☐ Stroke/Heart Disease
- ☐ Cancer
- ☐ Alcoholism
- ☐ Venereal Disease

Patient Informed Consent to Treatment

I, _____, have discussed with my Traditional Chinese Medicine Practitioner or Acupuncturist the specifics of my assessment or treatment and understand the nature, risks, and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, gua sha, and tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, if I am pregnant, if I am taking anticoagulants, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis.
5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. In some cases, my symptoms may temporarily worsen before they begin to improve.
6. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.
7. I have consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought.
8. **Cancellation Policy:** If you are unable to provide us with 24 hours' notice on cancelled appointments, there will be a charge for the full price of the appointment.

_____
Patient Name (Print)

_____ _____
Patient or Legal Guardian (Signature) Date