Jody
massage therapy clinic

Acupuncture Patient Health History Form

Patient Information		
First Name:	Last Name:	Middle Name:
Telephone (Home/Mobile):	Telephone (Business):	Sex: M / F / Other
Home/Street Address:	Apt #:	Date of Birth: (DD/MM/YY)
City: Province:	Postal Code:	Marital Status:
Occupation:	Email:	
Family Contact Information	First name:	Last name:
Relationship to Patient:	Phone Number:	Mobile Number:
Emergency Contact information (If different individual from above)	First name:	Last Name:
Relationship to Patient:	Phone Number:	Mobile Number:
Family Doctor Name:		
Clinic Address:		
Clinic Phone:	Clinic Email:	

Past Medical History

Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.

Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment

Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.

Please circle any conditions you are experiencing (past and present):

General Symptoms
Headaches/migraines
Fever
Chills
Sweat
Memory loss
Dizziness/Light headiness
Fainting
Stress/depression
Discoordination
Nervousness
Recent weight loss/gain
Numbness pain in arms, legs

Respiratory
Wheezing
Chronic cough
Spitting up phlegm
Chest pain
Difficulty breathing

Muscle and Joint
Stiff neck
Back ache
Swollen joints
Painful tailbone
Pain in shoulder
Hernia
Spinal curvature
Faulty posture
Arthritis
Foot trouble

Cardiovascular
High or low blood pressure
Previous stroke or TIA
High cholesterol

Swelling of ankles
Poor circulation
Stroke/heart attack
Irregular heart beat
Shortness of breath
Pain over heart

Genitourinary System
Frequent/painful urination
Blood in urine/stool
Mucus in stool
Kidney infection/kidney stone
Bladder infection
Inability to control urine

Ears, Eyes, Nose, Throat
Hearing loss
Vision problems
Glaucoma
Ringing in ear(s)
Crossed eyes
Eye pain
Deafness
Earache
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma

Dental decay
Gum trouble
Frequent colds
Enlarged thyroid

Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

Skin
Skin conditions/rashes
Itching
Bruise easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy

Gastrointestinal
Poor appetite
Distress from greasy foods

Excessive hunger/thirst
Belching or gas
Nausea
Vomiting
Burning in stomach
Pain over stomach
Constipation/diarrhea
Colon trouble
Liver trouble/hepatitis
Gall bladder
Ulcers

Colitis
Hemorrhoids
Hypoglycemia
Hiatal hernia

Metallic taste

For Women Only
Cramps/backache
Previous miscarriage
Irregular cycle
Vaginal discharge
Lumps in breast
Menopausal symptoms

Pregnant
Painful menstruation
Excessive flow
Hot flashes
Hysterectomy

Have you had any of the following?

Appendicitis	Malaria	Chicken pox	Alcoholism	Osteoporosis
Diabetes	Venereal infection	Cold sores	Whooping couch	Cancer
Epilepsy	Multiple sclerosis	Anemia	Heart disease	Tuberculosis
Pneumonia	Measles	Goiter	Eczema	Mental illness
Mumps	Influenza	Gout	Polio	Pleurisy
Pneumatic fever	Arthritis	Rubella	Parkinson's	HIV/AIDS

Signature of Patient: _____ **or Substitute Decision-Maker:** _____

Date:_____ **Relationship to Patient:** _____

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Patient Informed Consent to Treatment

I, _____ consent to have _____
[name of patient] [name of practitioner]

perform the following treatment* on me:
Describe specific treatment or plan of treatment. For example, acupuncture and herbal prescription for 8 weeks, with at-home exercises. [Note that the practitioner should not obtain a "blanket consent" to cover every procedure when the patient first comes in.]

_____

_____

_____

_____

_____

*If treatment includes sensitive areas, I, consent to have _____ , provide assessment and/or treatment of the areas indicated below:
[please check the appropriate box(es)]

- □ Upper and inner thigh
- □ Vagina
- □ Buttocks
- □ Breasts
- □ Penis
- □ Chest wall muscles

I acknowledge that _____ has explained the following to me:
[name of practitioner]

- the nature of the treatment, as set out above
- if applicable, the clinical reason(s) for the assessment of the above sensitive area(s) and the draping methods to be used the expected benefits of the treatment
- the material risks of the treatment
- the material side effects of the treatment
- the alternatives to having the treatment
- the likely consequences of not having the treatment

I acknowledge that my practitioner cannot guarantee the results of the proposed treatment.

I acknowledge that I have informed my practitioner about my relevant health history, including whether I have any allergies, metal implants, if I suffer from any type of major bleeding disorder, if I use a pacemaker, or if I have any infectious viruses or diseases.

I understand that my consent is voluntary, and I have the right to withdraw my consent to the treatment at any time.

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. I acknowledge that my practitioner has explained the applicable fees to me.

I acknowledge that 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 the treatment set out above.

Signature of Patient/SDM: _____ **Date** _____

By signing this form, I acknowledge that I have reviewed the form with the patient (or substitute decision-maker) and have answered the patient's (or substitute decision-maker's) questions.

Practitioner's Signature: _____ **Date:** _____