Acupuncture Patient Information Form

Name:_____ Birth date(M/D/Y): _____Marital Status: **S M CL W D**
(please circle one)
Address:_____ City:_____ Postal Code:_____

Home Phone#:_____ Work#:_____ Cell #:_____

E-mail address:_____ Referred to us by:_____

Occupation:_____ Employer:_____

#of children and ages :_____
Emergency Contact:_____, relation to you:_____ Phone#:_____
Family Physician:_____ Location:_____

Is this condition part of an ICBC or WCB claim? **Y/N** **If yes, please ask for additional forms.**
Have you obtained an attorney? **Y/N** If yes, attorney's name:_____

What is the primary reason you are seeking treatment?
_____
_____
Other complaints?_____
Are these symptoms: **A)** getting worse **B)** improving **C)** about the same **D)** come and go ?

Previous Illnesses:_____
_____
Surgeries (give dates):_____
_____
Do you have hepatitis or any other infectious diseases?_____
_____
Any uncommon Childhood Illnesses? _____
_____
Describe any occupation- related stress: _____
_____
Describe type and frequency of any exercise program:_____
_____
Traumas (accidents, falls, etc) :_____
_____
Allergies (Foods, drugs, etc) :_____
_____
Are you on ANY medication/supplements(drugs, vitamins, herbs, etc)?:_____
_____
_____

Female only: Are you pregnant? **Yes/No/Maybe**

Please complete reverse side⇒ ⇒ ⇒

Check the items you use and indicate frequency: (___)Coffee_____ (____)Cigarettes_____
(___)Alcohol_____ (___)Recreational drugs_____ (___)Cola _____

Describe your typical diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snack: _____

From the following list of symptoms:
Write "**1**" beside those you experience occasionally or mildly
Write "**2**" beside those you experience frequently or moderately severely
Write "**3**" beside those that are disabling or persistent

___ Fatigue
___ Loss of Appetite
___ Indigestion
___ Abdominal bloating
___ Binge Eating
___ Nausea
___ Vomiting
___ Loose stool
___ Diarrhea
___Constipation
___Muscular weakness or spasm
___sudden weight loss
___Flatulence
___Bad Breath
___sores in mouth or on tongue
___Stomach ache
___ Fevers
___ Sweating without exertion
___night sweats
___ hot, painful joints
___ skin eruptions/rashes
___ thirst
___ insomnia
___ heat in palms and soles
___ easy bruising
___ chronic sore throat
___ nosebleeds
___ lymphatic swelling
___ palpitations
___ poor memory
___ difficult concentration
___ irritable/jittery
___ ringing in ears
___ loose teeth
___ hair loss
___ dizziness
___ loss of balance
___ hearing loss
___ weak knees and legs
___ increased sexual energy
___ decreased sexual energy
___ burning or urgent urination
___ frequent urination
___ incontinence
___ low back pain
___ broken bones
___ water retention
___ headaches/migraines
___ blurry vision
___ sore or dry eyes
___ eye infections
___ neck and shoulder tension
___ chest discomfort
___ genital problems
___ numbness or tingling
___ soft of brittle nails
___ dry skin
___ acne
___sinus infections
___ cough
___ wheezing
___ shortness of breath
___ decreased sense of smell
___ post-nasal drip
___ nasal congestion or discharge
___ aversion to heat or cold
___ feeling of "spaciness"
___ bitter taste in the mouth
___ haemorrhoids

Acupuncture/Injection
Patient Consent Agreement

This case history from will be kept as part of your patient file.
All information within your file, including the case history, will be kept confidential and will not be released without your prior consent.

I do herby give consent to Dr.Chris Vallee to use acupuncture and/or injection therapy.

I understand that there are risks involved in having any type of acupuncture and/or injection, which may result in an allergic reactions, punctured lung, nerve damage and irritation causing partial paralysis. Some injections may make you feel ill or create a healing reaction that is unpleasant to experience.

Allergic reactions can sometimes be very serious, and in some cases be fatal.
Allergic reactions are rare, but do happen.

I understand all the risks involved, and I am willing to allow Dr. Chris Vallee to use acupuncture and or/injections in the course of my therapy, and hold him blameless of any and/or all consequences and/or reaction that occurs in the course of any acupuncture and/or injection performed by him.

Your appointment time is especially reserved for you. If it is necessary to reschedule an appointment Please allow 24 hours notice so we may give your time to someone else, otherwise it may be necessary to charge you $25 for each ½ hour (barring emergencies).

Please sign below that you understand the above information and the information you provided in This case history is accurate. Signing will also indicate your consent in treatment.

Thank you for your co-operation.

Signature : _____ Date : _____