Elevate Life Acupuncture & Traditional Chinese Medicine

Today's Date: _____
(mm/dd/yyyy)

Full Name: _____ Birth Date: _____
(mm/dd/yyyy)
Age: _____ | __Male / __Female AHC:_____
Full Address: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Occupation: _____
Emergency Contact Name: _____ Phone: _____
Relation to Emergency Contact: _____
Physician Name: _____ Phone: _____
Whom can we thank for your referral? _____
Email*:_____

(*By providing my email, I consent Elevate Life to send me appointment reminders and news letter updates to my email as indicated above.)

Have you ever experienced any of the following?

__Arthritis
__Asthma
__Allergies/Skin rashes
__Bleeding disorders
__Cancer/Tumor
__Cold sores
__Diabetes
__Fertility issues
__Genital pain/issues
__Goiter/Thyroid disorder
__Gout
__Heart disease/Stroke
__Hepatitis
__HIV/AIDS
__High blood pressure
__Intestinal disorders
__Organ disease
__Prostate problems
__Tuberculosis
__Urinary tract infections
Other: _____

Are you <u>currently</u> experiencing any of the following?

__Cold/Flu/Cold sore
__Infection/Inflammation
__Pregnancy/Lactation

Are you wearing any electronic devices or have any electronic or metal implants (hearing aids, pacemaker, etc.)? _____

<u>Family History:</u> Please check if any blood relatives have had any of the following:

__Allergies
__Arthritis
__Asthma
__Cancer/Tumor
__Diabetes
__Fertility issues
__Heart disease/Stroke
__High blood pressure
__Organ disease
__Seizure disorders
__Tuberculosis
Other: _____

Are you currently taking any medications (therapeutic or recreational)? Please indicate the name, dosage, and use of the medication.

_____

_____

Please list any medication, food, or environmental allergies you experience including the reaction you have:

_____

_____

<u>Females:</u> Please answer the following questions if applicable:

# of pregnancies: _____ # of births: _____ Relevant notes: _____

Age of first menstrual period: _____ Age of Menopause: _____

Time between menstrual cycles (days): _____ Length of bleeding (days): _____

Flow: __Heavy / __Light | Color: __Dark / __Bright | Clots: __Yes (Size:_____)/__No

Pain: __Yes / __No | Breast tenderness: __Yes / __No | Mood changes: __Yes / __No

Currently using birth control: __Yes / __No | Type: _____ How long: _____

Birth control in the past: __Yes / __No | Type: _____How long: _____

What is the reason for your visit today?

_____

_____

Have you received acupuncture treatments before? __Yes / __No

How long ago if yes: _____ Did it help? _____

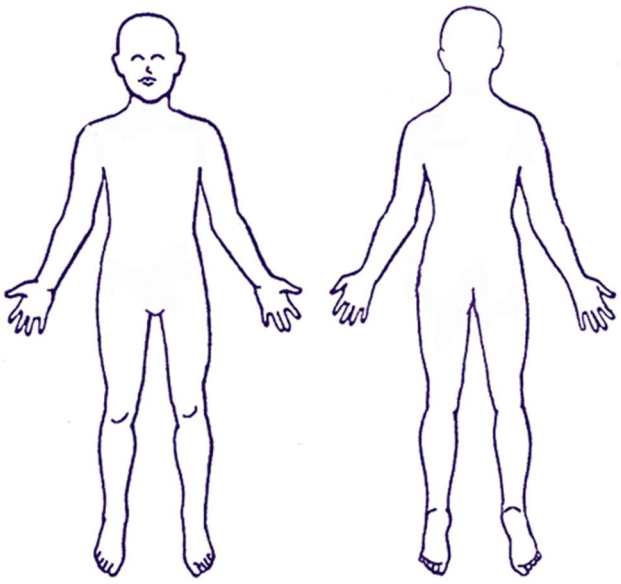
What treatments have you tried? _____

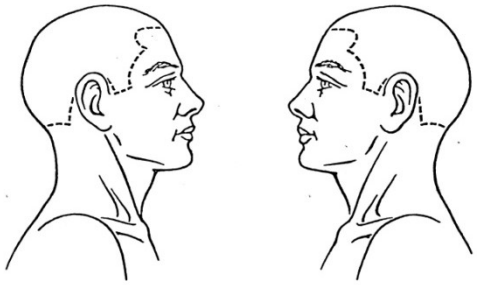
_____

What makes it better?:_____

What makes it worse?: _____

Please indicate any areas of discomfort in the diagram below:





"It's no coincidence that four of the six letters in health are 'heal'".

- Ed Northstrum

Cancellation Policy

Elevate Life Acupuncture & Traditional Chinese Medicine will gladly accommodate changes to your scheduled appointment, including cancellations, when we are given **48hrs notice**. We understand that unforeseen circumstances may arise, however, with respect to the practitioner's time and to allow the time to be given to others who may need the appointment, we require notice of any changes which need to be made to your appointment. **Failure to show up to a scheduled appointment may result in a charge for the full appointment time.**

Please initial to state that you have read and understood the cancellation policy and will adhere to our cancellation policy. _____

Acupuncture Consent to Treatment

I understand that section 8(1) of the Alberta's Acupuncture Regulation stipulates that an Acupuncturist shall not undertake the care and treatment of a person unless

a) that person has already consulted with a physician or in the case of dental pathology, a dentist, about the condition for which care and treatment from the acupuncturist is being sought;
b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and
c) the acupuncturist has completed a patient consultation form

Have you consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought? __Yes / __No

I understand that the acupuncture, acupressure, cupping, GuaSha (scrapping), and/or electro-stimulation is performed by the insertion of needles through the skin or by pressure/suction at certain points on the body in an attempt to treat bodily dysfunctions or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain, or discomfort, electrical shock, and possible aggravation of symptoms existing prior to treatment. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop and/or refuse treatment at any time.

Chinese Herbs: I understand that Chinese herbs may be recommended in an attempt to treat bodily dysfunctions and diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do choose to take them. I am aware that certain adverse side effects may result from taking these medications. Should I experience any problems, which I associate with these medications, I should suspend taking them and advise the acupuncturist as soon as possible.

By signing below, I have clearly read and understood all of the above information and am fully aware of the benefits and risks associated with treatment. I understand that I may ask my practitioner for more detailed explanations. I do hereby consent to be treated with acupuncture/acupressure, cupping, GuaSha (scrapping), and/or electro-stimulation and/or Chinese herbs by:

Elevate Life
1804 – 1st Street NW, Calgary, AB T2M 2T2

Signature: _____ Date of consultation: _____
Patient Name: _____ (mm/dd/yyyy)