BROADWAY WELLNESS

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ACUPUNCTURE - NEW PATIENT INTAKE FORM

Please take time to fill out the following form carefully. Your answers will help to properly assess your situation and will also provide a basis for further questions during your visit. All information is confidential and for office use only.

General Information

First Name: _____ Last Name: _____ Date of visit: _____

Date of Birth: Y _____ M _____ D ____ Age: ____ Gender: _____ Marital Status _____

Address: _____

City: _____ Postal Code: _____ Occupation: _____

Email Address: _____ Primary Phone #: _____

Emergency Contact: _____ Contact Phone #: _____

Family Doctor: _____ Family Doctor Phone # (if know): _____

Please list recent health care practitioners that you've seen and when? _____

_____

_____

How did you find out about the Acupuncture services at this clinic? _____

Health Insurance

Personal Health (MSP) #: _____

Do you have an active ICBC or WCB claim? ☐ Yes ☐ No

Extended Healthcare Insurance Company (if applicable): _____

_____

_____

_____

_____

Main Problem

What is your major health concern?

Please describe your current symptoms:

How long have you had the main condition:

☐ less than 6 months ☐ 6 months to 1 year ☐ 1-5 years ☐ 5 years or more

How did it start?:

What aggravates your condition?:

Medical History

Have you been to see your family doctor regarding this problem? ☐ Yes ☐ No

If yes, what was the medical diagnosis?

_____

_____

Please check if you have had any of the following diseases or conditions in the last three months.

☐ High blood pressure	☐ Low blood pressure	☐ Heart condition	☐ Respiratory condition
☐ Circulatory disorder	☐ Dizziness/fainting	☐ Arthritis	☐ Diabetes
☐ Osteoporosis	☐ Irritable bowel/colitis	☐ Epilepsy	☐ Other seizure disorders
☐ Urinary condition	☐ Contagious condition	☐ Asthma	☐ Spinal injury/condition

Have you had any surgeries? If yes, please specify what surgery:

_____

_____

Do you have or have any tattoos or piercings? If yes, please list the locations of tattoos or piercings?

_____

_____

Please list any other pre-existing conditions: _____

_____

_____

Are you taking any medications? If yes, please list all medications: _____

_____

_____

What other treatments have you tried?

☐ Massage (RMT)	☐ Naturopathic Medicine	☐ Physiotherapy	☐ Chiropractic
☐ Athletic Therapy	☐ Osteopathy	☐ Other	

Have you tried acupuncture before? ☐ Yes ☐ No

Do you have any metal allergies? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Informed Consent to Treatment and Cancellation Policy

Informed Consent to Treatment:

I hereby consent to receive treatment offered by Brian Kushniruk R.Ac. I certify that all of the medical history provided is true to the best of my knowledge and I have not knowingly omitted information.

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. Treatments include, but are not limited to acupuncture, acupressure, cupping, moxibustion, gua sha and laser acupuncture. Before any of those procedures are performed the practitioner will discuss treatment options and only proceed of consent is given.

I understand the potential risks of these procedures which can include drowsiness, fainting, and injury from acupuncture which can include slight pain, soreness, bruising, bleeding or discolouration of the skin and the potential for unforseen risks. I freely accept the risks involved with treatment.

I understand that I must let my practitioner know if I am carrying or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.

With this understanding, I voluntarily consent to treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that Brian Kushniruk R.Ac. will keep a record of health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or by my representative in writing or unless required by law. I understand that my medical records will not be kept for more than (10) years after the day of my last appointment. I understand that any questions concerning this form may be asked of the registered acupuncturist.

Cancellation Policy:

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, 24 hours notice is required for any cancellations or changes to your appointment. Patients who provide less than 24 yours notice, or miss their appointment, will be charged a 100% cancellation fee.

Signature: _____ Parent/Guardian Signature: _____

Date :_____