HOLISTIC WELLNESS
OTTAWA

Acupuncture and Tui na Massage

Emily Dunn, RAc

Thank you for taking the time to fill out the requested information. Everything disclosed is confidential.

Date: _____

Name: _____ Date of Birth (dd/mm/yy): _____

How did you find out about us? _____

What is your main reason(s) for coming today? _____

_____

How much change in diet and lifestyle are you willing to make to improve this condition?

none / a small amount / a great amount

LIFESTYLE

What quantity, per day, do you drink on average of the following?

Coffee_____ Tea_____ Milk _____ Herbal tea_____ Alcohol_____ Water_____ Juice_____ Soda_____

What alcoholic beverages do you drink? _____ How often? _____

Do you smoke?_____ If so how many per day?_____ At what age did you start? _____

What do you do for exercise, recreation and relaxation?_____

_____

Please mark therapies used presently (**√**) or in the past (**P**):

Massage _____ Chiropractic _____

Physiotherapy_____ Acupuncture _____

Osteopathy _____ Other, please specify: _____

Reiki _____ _____

MEDICAL HISTORY

List any Medication / Nutritional Supplements you are taking, what you are taking them for and when you started them?_____

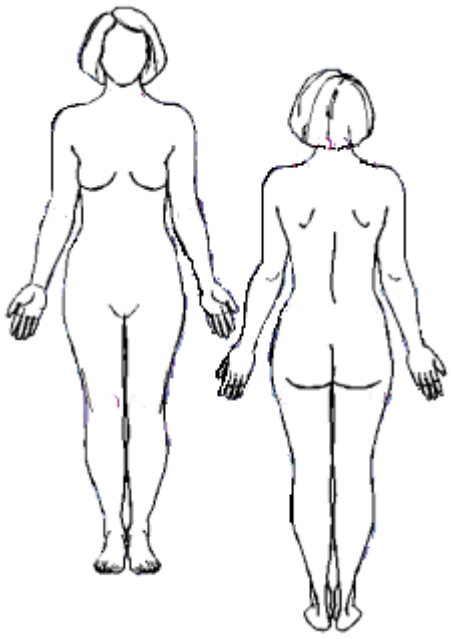
_____

_____

Name: _____

Do you have any physical pain or discomfort at this time? Y / N

If yes, please indicate where on the diagram:



Right Left Left Right

List any surgeries in the past 5 years: _____

_____

List any injuries requiring medical care in the past 5 years: _____

_____

_____

List any internal pins, wires, artificial joints or other implants in place: _____

_____

Are you allergic or hypersensitive to silicone? Y / N

List anything you are allergic or hypersensitive to: _____

_____

Are you currently pregnant, or is there a chance that you may be pregnant? Y / N _____

List any loss of body sensation or balance and when it occurred: _____

_____

Lit anything you are currently being treated by a health care practitioner/medical doctor for: _____

_____

Practitioner/Dr.: _____ City: _____ Province: _____

Name: _____

Please place a checkmark (**√**) next to any of the following symptoms that you currently experience and a (**P**) next to any that you have had in the past.

SKIN & HAIR
- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Boils/Cysts
- ☐ Acne
- ☐ Hives
- ☐ Warts
- ☐ Dryness
- ☐ Colour changes
- ☐ New/Changed moles
- ☐ Lumps
- ☐ Dandruff
- ☐ Hair loss
- ☐ Change in hair texture
- ☐ Nail changes
- ☐ Other, specify:_____

EYES
- ☐ Impaired vision
- ☐ Glasses/contacts
- ☐ Far-sighted
- ☐ Near-sighted
- ☐ Double vision
- ☐ Colour blindness
- ☐ Night blindness
- ☐ Sensitivity to sun
- ☐ Pain
- ☐ Redness
- ☐ Itching
- ☐ Dryness
- ☐ Discharge
- ☐ Blurring
- ☐ Excessive tearing
- ☐ Spots/Floaters
- ☐ Blind spot
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other, specify:_____

NOSE & SINUSES
- ☐ Allergies
- ☐ Loss of smell
- ☐ Post nasal drip
- ☐ Nosebleeds
- ☐ Dryness
- ☐ Sinus infections
- ☐ Sinus pain
- ☐ Nasal congestion
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Nasal Polyps
- ☐ Other, specify: _____

EARS
- ☐ Ringing/ Tinnitus
- ☐ Discharge
- ☐ Pain/Aches
- ☐ Deafness
- ☐ Infections
- ☐ Wax build-up
- ☐ Ear tubes
- ☐ Other, specify: _____

MOUTH & THROAT
- ☐ Dental cavities
- ☐ Mercury fillings
- ☐ Gum problems
- ☐ Grinding/Clenching
- ☐ Ulcers/sores
- ☐ Loss of Taste
- ☐ Pain/Soreness
- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Tonsillitis
- ☐ Phlegm/Mucous
- ☐ Cold sores
- ☐ Enlarged glands
- ☐ Jaw pain/clicking
- ☐ Facial pain/tics
- ☐ Other, specify: _____

HEAD & NECK
- ☐ Headache
- ☐ Migraines
- ☐ Injury
- ☐ Lumps
- ☐ Swollen glands
- ☐ Swollen lymph nodes
- ☐ Goitre
- ☐ Pain/stiffness
- ☐ Other, specify: _____

BLOOD & LYMPHATIC
- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Slow clotting
- ☐ Fatigue/weakness
- ☐ Pallor (paleness)
- ☐ Swollen lymph nodes
- ☐ Past transfusions
- ☐ Other, specify: _____

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Slow heart beat
- ☐ Palpitations
- ☐ Murmurs
- ☐ Angina
- ☐ Chest pain
- ☐ Swelling of limbs
- ☐ Cold hands or feet
- ☐ Thrombophlebitis
- ☐ Blood clots
- ☐ Varicose veins
- ☐ Elevated cholesterol
- ☐ Past ECG test
- ☐ Other heart tests
- ☐ Other, specify: _____

RESPIRATORY

- ☐ Cough
- ☐ Sputum
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Difficulty breathing
- ☐ Pain with breathing
- ☐ Shortness of breath (SOB)
- ☐ SOB lying down
- ☐ SOB at night
- ☐ Other, specify: _____

INFORMED CONSENT

Acupuncture is treatment involving the insertion and manipulation of fine stainless steel needles in specific points of the body to relieve certain ailments and improve general health.

Cupping is the use of suction cups to reduce pressure and draw skin and superficial tissue into the device in order to relieve pain and stasis by promoting proper blood circulation.

Electroacupuncture is the use of a small electric current between pairs of needle points to treat pain and to restore health and wellbeing by reducing inflammation and increasing blood flow.

Moxibustion is the application of indirect heat by utilizing moxa sticks to stimulate circulation around joints and articulations.

Heat Therapy by use of heat lamps (infrared or otherwise) or warming pads is the application of heat to relieve pain and contribute to general health.

Some possible minor side effects include:

- Mild bruising or pain at needle site
- Temporary aggravation of pain or symptoms
- Feeling faint or dizzy (possible result from fear or apprehension)
- Feeling tired or lightheaded

Some very uncommon, but serious complications include:

- Bacterial infections
- Pneumothorax (or collapsed lung) from needle inserted too deeply, entering the chest cavity.
- Nerve damage
- Needle breakage requiring surgical removal
- Kidney damage
- Brain damage or stroke
- Haemopericardium (damage to pericardium, heart's membrane)

I, the undersigned, have read and understood the above terms. I hereby give my voluntary consent for the administration of therapy, which may include, but is not limited to, acupuncture, cupping, electroacupuncture, moxibustion and heat therapy.
I understand the risks involved and all relevant questions and concerns have been answered.

I verify that the information I have given on this form is true and accurate. I acknowledge that I am receiving TCM therapy and that my record may be used for informational purposes. I acknowledge that my clinic file may not be used for insurance claims or for the intent of representing a medical authority. I acknowledge that I may or may not be reimbursed by my insurance company, but am responsible for payment regardless. I also acknowledge that it is my responsibility to update my treatment file and advise the therapist of any changes in my health status.

Name (print): _____ **Signature:** _____ **Date:** _____

Emergency Contact: _____ **Telephone:** _____

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