HOLISTIC WELLNESS
OTTAWA

Acupuncture Intake

Dr Stacia Kelly

Confidential Patient Information

First Name:_____ Last Name:_____

Date of Birth (DD/MM/YYYY)_____ Age:_____

Address: _____ City: _____Province: _____ Postal Code:_____

Phone (home):_____work:_____ cell:_____

Marital Status:_____ Occupation:_____ Employer:_____

Height:_____ Weight:_____

How did you hear about the clinic (or who)?_____

Have you ever received Acupuncture? If so, when/who _____

Reason for Visit

What is your major current complaint(s)? _____

When did this start/how long? _____

Have you had similar condition on the past? If Yes, When? _____

Are you experiencing any numbness or tingling? If Yes, Where?_____

What activities aggravate your complaint? _____

Other Doctors/ Therapists seen for this condition? _____

Have you had x-rays taken? _____

Is this condition a result of a motor vehicle or work related accident? _____

Current Medical Information

(Please check if you have now or had in the past)

Headaches	Pins & Needles in legs	Fainting
Neck pain	Pins & Needles in arms	Loss of smell
Sleeping Problems	Numbness in fingers	Loss of taste
Back pain	Numbness in toes	Diarrhea
Nervousness	Shortness of breath	Cold feet
Tension	Fatigue	Cold Hands
Irritability	Depression	Stomach upset
Chest pain	Lights bother eyes	Constipation
Dizziness	Loss of memory	Cold sweats
Face flushed	Ringing in the ears	Loss of balance

Family Physician Name:_____ Last Physical Exam Date:_____
Current medications:_____
Past Serious Injuries:_____
Past Surgeries/Hospitalizations: _____
Sport injuries? Traumas? Fractures? Sprains? _____
Allergies/Sensitivities? _____
Number of Pregnancies (if applicable)? _____
Do you Exercise? (What type?)_____
Do you smoke? _____ Drink Alcohol?_____
Age of Mattress?_____
Sleeping posture (side/stomach/back):_____
Do you currently have custom foot orthotics? _____

Family History

	Father's Side	Mother's Side
Heart Disease	Yes ☐	Yes ☐
Arthritis	Yes ☐	Yes ☐
Cancer	Yes ☐	Yes ☐
Diabetes	Yes ☐	Yes ☐
Stroke	Yes ☐	Yes ☐
High Blood Pressure	Yes ☐	Yes ☐
Other	Yes ☐	Yes ☐

Accident Information (if Applicable)

Have you been an accident recently? (within the last year) Yes ☐ No ☐
Work☐ Auto ☐ Other ☐ Date _____ Nature of Accident _____
Did you experience any symptoms after the accident? What? _____
Did you feel popping or tearing noise in back of your neck? Explain _____
Did you require post-accident hospitalization? _____
Where? _____ When? _____ X-rays Taken? _____
Have you lost days at work? _____ Dates _____
Is insurance involved?_____ Which company, address:_____
_____
Attorney's name, if any_____ Claim #_____
Comments (Office use only)_____
_____
Have you been in an accident(s) in the past ? (over 1 year ago) Yes ☐ No ☐
Work☐ Auto☐ Other☐ Date_____

Details of the accidents(s) / Date(s) _____
_____
_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent for Acupuncture Care FORM - AC

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above-named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

Date Signed	Print Patient's Name	Signature of Patient (or parent/guardian)