ZEN | ACUPUNCTURE & WELLNESS

First Name:	Last Name:	Male/Female
Address:		
City:	Province:	Postal Code:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:		
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

_____

_____

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

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PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Dizziness
□ See floating black spots

□ Palpitations
□ Sore on tongue
□ Restlessness
□ Anxiety
□ Chest pain
□ Insomnia

□ Cough
□ Sinus congestion
□ Dry mouth, throat, nose, or skin
□ Allergies seasonal or food
□ Chills and fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet
□ Burning sensation after eating
□ Bad breath
□ Large appetite

□ Mouth, canker or cold sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea

□ Diarrhea alternating with constipation
□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shoot eyes/dry eyes
□ Anger easily
□ Skin rashes
□ Headache
□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions

□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears

Urine is:

□ Normal color □ Clear
□ Dark yellow □ Reddish
□ Cloudy □ Scanty
□ Bad odor
□ Burning □ Painful
□ Difficult □ Urgent

Libido (sex drive) is:

□ Normal □ Low □ High

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Women only:

1. Are you pregnant now?
□ Yes □ No

2. Number of children:_____

3. Number of pregnancies:_____

4. Age of first period:_____

5. Age of menopause if applicable:_____

6. Is your menses cycle regular?
□ Yes □ No

a. Average number of days in flow:____

b. The flow is:
□ Normal □ Heavy □ Light

c. The color is:
□ red □ dark □ purple
□ light brown □ brown

d. Do you have the following menstruation related symptoms?

□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

e. Birth control:_____

Men Only:

□ Discharge

□ Pain or swelling of testicles

□ Ejaculatory problems

□ Impotence/erectile dysfunction

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List any major disease or illness in your immediate family and indicate family member:

List all medications or supplements, including herbs and vitamins you are currently taking:

Occupation:

Do you have a regular exercise program? _____ Please describe.

Are you on a restricted diet? _____ What kind?

How much sugar/dessert do you eat per week?

How much dairy do you eat per week?

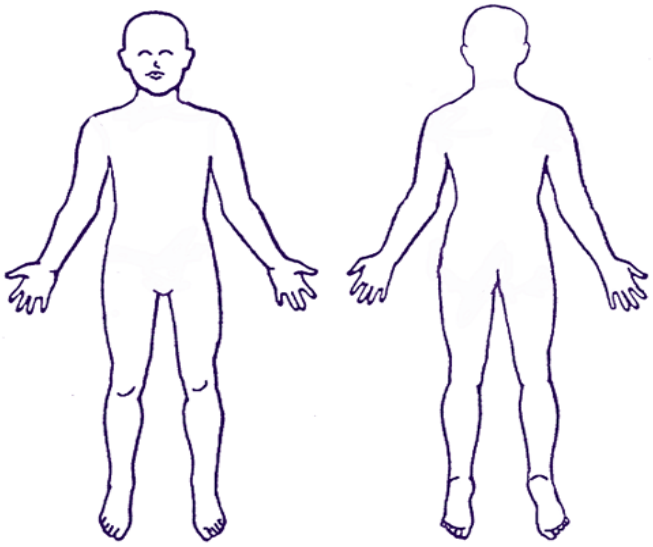
How many packs of cigarettes do you smoke per week?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Do you do any drugs? How much per week?

Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).



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Informed Consent

I understand that acupuncture treatments are a safe and natural form of healing and recognize the potential risks and benefits as stated below. Forms of treatment may include acupuncture, cupping, electrical-stimulation, acupressure/massage, moxibustion, Chinese herbs, and dietary / lifestyle recommendations.

Potential benefits: Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of the main complaint(s).

Potential risks: Although uncommon, there is a potential for acupuncture treatment to cause temporary bruising, swelling, bleeding, numbness, tingling and soreness at the site of the needle and such symptoms may last a few days. Unusual risks associated with acupuncture include dizziness, fainting, nerve damage, or possibly the aggravation of symptoms existing prior to treatment. Pneumothorax is a very rare and unlikely side-effect of acupuncture. Although extremely unlikely, infection is a minor possibility even through the use of sterile, one-time-use, disposable needles. Abiding to Canadian law, these are the only type of needles to ever be used in this clinic and a clean and safe environment is maintained at all times.

Moxibustion and cupping treatments carry the potential risks of temporary bruising or blistering. I understand that I will not make any large movements during the acupuncture treatment, and that some articles of clothing may need to be removed in order to gain access to areas of the body under treatment.

Pregnancy: Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process, or postpartum. I will notify my acupuncturist should I become pregnant, or if I am in the process of trying to become pregnant so that my practitioner can avoid points that could induce premature labor or miscarriage.

Cancellation Policy: I understand that scheduling an appointment involves the reservation of time at the clinic specifically for me, and I agree to give at least 24 hours of notice to cancel or reschedule an appointment. I will be charged $35 for treatments missed without sufficient notice.

Privacy: I understand that records will be kept by the clinic of services provided to me. These records will be kept confidential and will not be released to anyone unless specifically directed by me in writing. I may look at my patient file at any time, and can obtain a copy by paying the appropriate photocopying fee.

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

_____	_____	_____
*Printed Patient Name	*Patient Signature	*Date

_____	_____
Parent/Guardian Name (if under 18)	Parent/Guardian Signature