CORE INSIGHT CHIROPRACTIC
40 Aberdeen Avenue, Suite 103, St. John's, NL A1A 5T3 709.738.0366 www.coreinsight.ca

Acupuncture Intake Form

Section 1

Name: _____

☐ Please tick if you are a current patient of this clinic (continue below the boxed area)

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Tel: _____ Business/Cel Tel: _____ Ext: _____

E-mail: _____

Emergency Contact: _____ Tel: _____

Date of Birth: _____ Age: _____

Medical Doctor

Name: _____ Tel: _____

Address: _____

Are you currently seeing a medical specialist? **Y** **N**

Reason: _____

What is your main complaint? _____

_____

How long have you had this problem? _____ years, _____ months

What aggravates your main complaint? ☐ Not sure

☐ Heat ☐ Cold ☐ Rest ☐ Exercise ☐ Damp weather

☐ Mood ☐ Stress ☐ Diet ☐ Sleep ☐ Windy weather

☐ Time of day ☐ Weight ☐ Caffeine ☐ Lack of sleep ☐ Alcohol

☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

Is there anything that makes it better, even if only temporarily? **Y** **N**

☐ Heat ☐ Cold ☐ Rest ☐ Exercise ☐ NDAIDS (e.g. Tylenol)

☐ Massage ☐ Other therapy ☐ _____ ☐ _____ ☐ _____

Concurrent Health Therapies or Regimes: _____

_____

Prior Acupuncture Care

Name of Practitioner: _____ Date of Last Visit: _____

Was this person a/an (please circle):

Acupuncturist Medical Doctor Chiropractor Physiotherapist Other: _____

Were you pleased with the results? **Y** **N**

Medications

Please list any medications and/or natural health supplements you are taking and the condition(s) they are treating: _____

_____

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Medical History

Does **your** medical history include:

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Rheumatic fever
- ☐ STD's
- ☐ Birth trauma
- ☐ Childhood illnesses
- ☐ Vaccination reactions
- ☐ Accidents/major trauma
- ☐ Other: _____
- ☐ Surgeries (please list): _____

Do you **currently** suffer from (please check all that apply):

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Recent appetite change
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sensitive to tastes/smells
- ☐ Cravings
- ☐ Excess thirst
- ☐ No thirst
- ☐ Bleeding/bruising easily
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Insomnia
- ☐ Sleepiness
- ☐ Chills
- ☐ Poor coordination
- ☐ Tremors
- ☐ Localized weakness
- ☐ Poor balance
- ☐ Cold back
- ☐ Excess dreaming
- ☐ Cold hands
- ☐ Cold feet
- ☐ Fevers/hot flashes
- ☐ Cold abdomen
- ☐ Night sweats
- ☐ Spontaneous sweating
- ☐ Sudden drop in energy (approximate time of day): _____

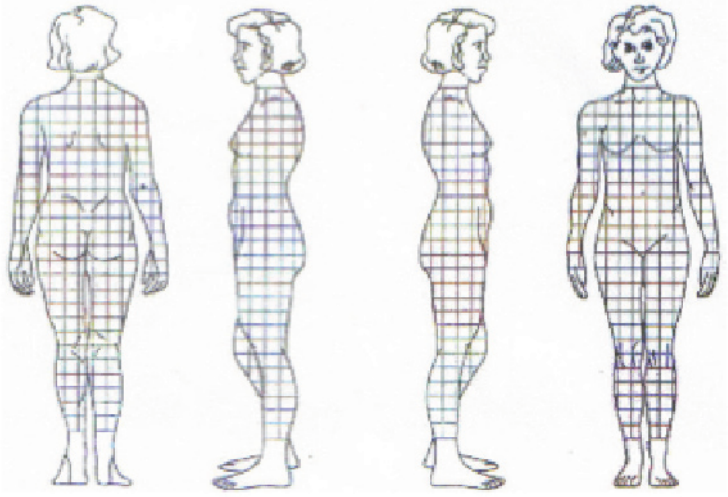
Please tale a moment to reflect on your **present sense of well-being**, remembering to take into account your physical, mental, emotional, social and spiritual condition. Use an **X** to mark the point on the line below that best represents your sense of well-being over the past month.

Worst you have ever felt **Best you have ever felt**

Pain

Please draw the location of your pain or discomfort on the images below using the symbols shown to represent the different types(s) of pain:

D = Dull **S** = Stabbing/sharp **B** = Burning **N** = Numb **T** = Tingling **C** = Cramping



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Do you have any other information you feel may be helpful for us to know concerning your current condition, diagnosis and/or treatment? _____

_____

_____

Disclosure Statement and Informed Consent

Fee Schedule

(payment due at time of service)

Acupuncture:		Fire Cuppung/Guasha:	
First treatment:	$80.00	First treatment:	$80.00
Follow-up:	$75.00	Follow-up:	$75.00

Insurance: Acupuncture is not a eligible modality for direct billing, however we will provide you with a receipt for you to remit to your insurance company.

Please note: All appointments that are cancelled/rescheduled with less than 24 hours notice and appointments missed without notice will be charged a fee of $50.00.

Informed Consent

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist Michelle Murray, D.Ac, R.Ac. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Patient Name (please print)	Signature of Patient or Authorized Representative	Date