ArteSana Acupuncture - Intake and consent of treatment

	ArteSana Acupuncture **The Art of Healing** **Martha Colorado** Registered Acupuncturist &Herbalist TCMP- B Psych 308-4885 Kingsway,Burnaby -BC. V5H 4T2 Tel. (778)892-7207 • marcoloclinic@gmail.com	Premium Assistance? Yes No Care Card Number:_____ Today's Date: _____/_____/_____ month day year

NAME: _____BIRTHDATE:_____

MALE:_____FEMALE:_____ AGE:_____

ADDRESS: _____

CITY:_____POSTAL CODE:_____

HOME PHONE: _____EMERGENCY PHONE: _____

Do you have children (#/ages):_____

Email:_____Family Doctor:_____

Employment Status: Full Time___ Part Time__ Student __ Retired __ Unemployed Other:_____

Referred by_____

What are the major health concerns that brought you here today?_____

_____

When did this condition begin?_____

Your physician diagnosis: _____

Are you on any medication?___ Please indicate:_____

Do you use regularly use the following? If so, please indicate how often:

Cigarettes: _____Alcohol: _____Drugs: _____

Are you: a Vegetarian: _____

For women : Pregnant: _____ Due Date:_____

Do you have any infectious diseases that you know of? _____Please indicate:_____

Have you ever been hospitalized and/or treated for an infectious disease? If so, for what condition/disease?

_____

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc)?

_____

Have you ever undergone surgery or been hospitalized? (Please provide the date and reason)

_____

Do you exercise regularly? ____ Frequency? _____times/week What Type of exercise?_____

_____

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Please describe if any accidents, injuries or surgeries in the last five years:_____
_____

Have you ever been treated with Traditional Chinese Medicine: ____When:_____

What goal(s) do you have for your health care at this time? _____
_____

Please indicate if you believe if any of the following apply to you.

P=Past C=Current

____ Hypertension	_____ Headaches/Migraine	_____Joint dislocation
____ Low blood pressure	_____Dizziness or vertigo	____Bone fracture
____ Heart Attack	_____Nausea	_____Arthritis
____Stroke or Aneurysm	_____Spinal Injury	_____Osteoporosis
____Peace maker	_____Head Injury	_____Rods/pins/prosthetic/artificial joints
____other heart condition	_____Epilepsy/Seizures	_____Implants
____Varicose veins	_____Stroke _____Other neurological condition	_____Transplants
____Bruise easily		_____Contact lenses
____Palpitations	___Night sweats	
____Other circulatory condition	___Thirst	_____Cancer
		_____Hepatitis
____Diabetes	_____Asthma	_____HIV
____Kidney disease	____Chronic sinusitis	_____Other contagious condition
____Other urinary condition	_____Other respiratory conditions	
____Insomnia	_____Irritable bowel syndrome	
____Depression	_____Digestive condition	_____
____Anxiety	_____Constipation	_____
____Stress	____Haemorrhoids	_____
____Other _____	_____Skin condition	
Any other health concerns:		
Other alternative treatment or therapy? (past/present)		
Chiropractor_____	TCM/Acupuncture_____	Physiotherapy_____
Naturopath _____	Other_____	

INFORMED CONSENT OF TREATMENT

PLEASE READ THE FOLLOWING CAREFULLY:

You are going to receive a Traditional Chinese Medicine (TCM) and complementary treatment; which may include acupuncture, herbal medicine, cupping, electroacupuncture, food diet recommendations, Acupoint injection therapy or biopuncture.

Potential risks: discomfort, pain, nausea, temporary discoloration at site of procedure, fainting, weakness, bruising.
Potential benefits: drugless relief of presenting symptoms and improved balance of body's energies, which may lead to prevention, elimination of the presenting problem and general improvement of health.

Your medical information and notes recorded during the consultation are kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.

Your appointment time is especially reserved for you. Please allow 24 hours to cancel an appointment otherwise a late cancellation fee will be charged or **if you did not cancel your appointment, full amount will be charged.**

I have had the opportunity to discuss with my Reg.TCM Practitioner MARTHA COLORADO the nature and purpose of my treatment and other procedures. I understand that there are no guarantees regarding cure or improvement of my condition. I understand and I was informed that there are some risks to acupuncture the treatment, such as those listed above.

I also understand that some herbs and acupuncture points may be inappropriate during pregnancy, so I will inform my TCM practitioner in case I suspect could be pregnant. I will immediately inform my practitioner if I experience any gastro-intestinal upset or allergic reactions to the herbs, treatments or procedures I had.

I have read, or someone have had read to me the above consent.

SIGNATURE_____ DATE:_____