ACUPUNCTURE & MASSAGE THERAPY INTAKE FORM

An accurate health history is important to ensure that it is safe for you to receive therapy. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law.

Name: _____ **Date Of Visit:** _____ **DOB:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Phone: _____ **Email:** _____@_____ **Occupation:** _____

Primary complaint/Injury: _____

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
  BP_____ Therapist Initials_____
  HR_____ Therapist Initials_____
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Heart Palpitations
- ☐ Phlebitis / varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Family history of any of the above?

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Chest Pain

Infections

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, where?
  _____
- ☐ Diabetes, onset: _____
- ☐ Allergies/hypersensitivity to what?_____
- ☐ Epilepsy
- ☐ Cancer when? Where? _____
  _____
- ☐ Skin conditions, what? _____
  _____
- ☐ Arthritis
- ☐ Dizziness / blackouts
- ☐ Loss of balance / coordination
- ☐ Vomiting / Nausea
- ☐ Difficulty swallowing
- ☐ Thyroid problems
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Broken bones/fractures
- ☐ Depression
- ☐ Recent infection (chest, urinary tract, etc.)
- ☐ Urinary problems
- ☐ Bowel Problems
- ☐ Fever / chills / sweats
- ☐ Weakness in Arms
- ☐ Weakness in Legs

Head/ Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Ear problems
- ☐ Hearing loss

Women

- ☐ Pregnant, due:_____
- ☐ Gynecological conditions, What?_____

Soft tissue / Joint discomfort:

Neck

- ☐ Low Back
- ☐ Mid Back
- ☐ Upper Back
- ☐ Shoulders
- ☐ Arms
- ☐ Legs
- ☐ Knees
- ☐ Other Medical Conditions_____
  _____
- ☐ Surgeries (type? date?)_____
  _____
- ☐ Presence of internal pins, wires, artificial joints?
  _____

General Health

- ☐ Have you recently had any unexplained weight loss? Loss of appetite? Night Sweats? ☐ Yes ☐ No
- ☐ Do you have unrelenting / constant night pain? ☐ Yes ☐ No
- ☐ Do you have a history of oral steroid use? (e.g. cortisone, prednisone) ☐ Yes ☐ No
- ☐ During the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No
- ☐ During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No
- ☐ Please share what has been missed _____

Emergency Contact Person: _____ **Relationship to you:** _____ **Phone:** _____

Family Doctor: _____ **Phone number:** _____

Current Medications(Attach list if needed):_____

Doctors Naturae: Practice & Dispensary

p: (905) 336-9621 **f:** (905) 336-9622 **e:** info@doctorsnaturae.com

Doctors PRACTICE Naturae DISPENSARY

ACUPUNCTURE & MASSAGE THERAPY CONSENT

In keeping with the Health Care Consent Act (1996) it is my choice to receive acupuncture or massage therapy. Therefore, I give consent for the Acupuncturist/Massage Therapist at Doctors Naturae, to carry out this treatment.

- I am aware that it is not necessary to remove all articles of clothing for treatment and I will remove clothing that I am only comfortable with removing;
- I am aware that I may experience possible side effects from the treatment, such as temporary discomfort within the muscles (24-72 hours post treatment), bruising and temporary dizziness;
- If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods can be adjusted to my comfort level;
- A feeling of nausea is common. The feeling usually passes shortly after the needles are inserted.
- A stuck needle can happen. This is easily corrected by relaxing the muscle until the needle is able to come out.
- I can communicate with the therapist at any time that I feel that my well-being is being compromised;
- I may terminate treatment at any point during the massage, at my discretion and without reason;
- Acupuncture/Massage therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.
- I agree to keep the acupuncturist/massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist part should I fail to do so.
- I understand that Acupuncturists/Massage professionals do not diagnose illness or disease or perform any spinal manipulations, nor do they prescribe any medicinal treatments.
- I agree to give 24 hours' notice to any appointment change, or I will be charged the full appointment time.
- I agree to email appointment reminders and accept that I am automatically enrolled in a monthly email newsletter. If I wish to opt out of this program, I can choose to do so by checking this box. ☐

* Please know that we provide an opportunity to unsubscribe from our letter with each email.

- I agree to the fees for the following sessions:

Initial Acupuncture – 90 minutes	$125.00
Initial Massage 60 minutes	$85.00
Pre-Paid Packages Massage or Acupuncture 5 sessions	$75.00
Follow Up Massage – 90 Minutes	$125
Follow Up Massage – 30 Minutes	$60.00

I _____ understand the procedure of Acupuncture/Massage Therapy that I will be receiving, to treat presented condition(s). I have read the consent form and I agree to each. It is also assumed that by signing this consent form, I agree to ongoing treatments until my therapist and I deem it advised.

Client's Signature: _____ **Date:**_____

Therapist's Signature: _____ **Date:**_____

Thank you for taking the time to fill out your form before your visit.

p: (905) 336-9621 **f:** (905) 336-9622 **e:** info@doctorsnaturae.com