Name: _____
Date: _____
AHC #: _____
Email Address: _____

BEACON HILL
CHIROPRACTIC AND MASSAGE

Under Canada's new anti-spam legislation, we are required to ask you for your consent to send you email reminders important information regarding your health.
Do you consent? _____ (YES) _____(NO) _____
Sign or Initial here

Acupuncture Confidential Health History Form

Name:_____Occupation:_____
Address:_____ Postal Code:_____
Home Number:_____ Cell Number:_____
Emergency Contact_____ Emergency Phone #:_____
DOB(M/D/Y):_____ Age:____ M/F:____ Height:_____ Weight:_____
Who referred you:_____
Main Complaint and Duration: _____
Secondary Complaints: _____
Please list any previous or current treatments you are undergoing: _____
_____
Please list all medications, vitamins and supplements you are currently taking:
_____
_____
Any personal or family history of any of the following, check those that apply with a P or F:
Heart Disease___ Respiratory Disease___ Stroke___ Diabetes___ Cancer___ Kidney Disease___ Arthritis___ Osteoporosis___ Neurological Problems___
Developmental Difficulties___ Allergies___ Gastrointestinal problems___

Any major injuries, accidents (including MVA), traumas (physical or emotional), hospitalizations or surgeries? If so please explain:
_____
_____

Check if you use any of the following and indicate frequency of usage:
Alcohol___ Nicotine___ Caffeine___ Illegal Substances_____
Do you have or suspect you have allergies or sensitivities? If so please list and describe related symptoms: _____
_____

If you are in pain, please indicate which best describes the pain:
Aching___ Stabbing___ Sharp___ Throbbing___ Tingling___ Numb___ Electric____
How bad is the pain on a scale of 1-10, 10 being the worst: 1 2 3 4 5 6 7 8 9 10
Location of pain:_____
Frequency of pain: Constant__ Off/On__ Daytime__ Nighttime__
Interferes with sleep or activity__
What makes it better:_____
What makes it worse:_____
Please list current physical activities and frequency: _____
_____
Please check off any of the following that apply to you:

Prefer warm food/beverages Prefer cold food/beverages Always thirsty Never thirsty Cravings Excessive appetite Poor appetite Abdominal discomfort Bloating/gas Nausea/vomiting Acid reflux/heartburn Eat how many times per day: How much fluid per day:	Constipation Diarrhea Alternating constipation and diarrhea Urgent bowel movement Painful bowel movement Loose stools Firm or hard stools Blood or mucus in stool Undigested food in stool Unusual odor Hemorrhoids Frequency of bowel movements:	Urgent urination Painful urination Frequent urination Scant/difficult urination Urinate at night Incontinence/dribbling Bedwetting Dark or cloudy urine Blood in urine Unusual odor Kidney stones Genital irritation or UTI Urinate how many times per day:
Sweat frequently Don't sweat or rarely sweat Sweat with activity Sweat with emotional stress Spontaneous sweating Sweat during specific time of day Night sweats	Headaches Migraines At top of head Sides of head/temples Behind eyes Back of head Neck and shoulders Sinuses Jaw Frequency of headaches:	Skin rash Excema/dermatitis Hives Facial or body acne Boils/pustules Dry skin/hair/nails Greasy skin Itchy skin Painful skin Easy bruising
Asthma Shortness of breath Acute cough Chronic cough Runny nose Stuffy nose Sore throat Enlarged lymph nodes Frequent colds/flus Emphysema/COPD	Poor vision Blurred vision Floaters Glaucoma Macular degeneration Dry eyes Red eyes Burning eyes Itchy eyes Runny eyes Glasses/contacts	Ringing in ears Recurrent ear infections Hearing loss Wax buildup Dizziness or vertigo Impaired balance Impaired sensory-motor skills Epilepsy/seizures/fainting Poor memory/concentration
Sleep well/feel rested Sleep poorly Difficulty getting to sleep Difficulty staying asleep Restless at night Nightmares Vivid dreams Difficulty waking Easily woken up Don't feel rested Tired during specific time of day Fall asleep during day Poor energy Fatigue Too much energy Hours of sleep per night: Go to bed at what time: Get up at what time: Naps:	Usually warm Usually cold Cold hands or feet Burning hands or feet Numbness in hands or feet Hot flashes Aversion to heat or cold Poor circulation High blood pressure Low blood pressure Chest pain Pacemaker Taking anti-coagulants Easy bleeding Excess bleeding Slow to heal Weakened immune system Recent weight gain/loss Thyroid imbalance Contagious/transmittable disease	**FEMALES ONLY**: Age of first period: Menopausal Hormone imbalance Irregular period PMS Heavy flow or clots Light flow Spotting between periods Duration of period: Length of cycle: Number of pregnancies: Miscarried or aborted: Pregnant or trying: STD or vaginal discharge Vaginal dryness Change in libido **MALES ONLY**: Erectile dysfunction Enlarged prostate STD Change in libido

Treatment Consent Form

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of Traditional Chinese Medicine (TCM) on me (or the patient named below, for whom I am legally responsible) by my Doctor of Acupuncture, and/or other Alberta registered acupuncturists who may treat me now or in the future while associated with or referred to herein as the Acupuncturist.

I understand the methods of treatment may include, but are not limited to acupuncture, acupressure, moxibustion, cupping, electrical stimulation, tui-na (Chinese massage), gua-sha, exercise prescription and lifestyle counseling. I understand that results are not guaranteed.

The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problems.

Potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, numbness, fainting, or nausea. Cupping commonly leave dark circular marks on the skin. These marks are never painful and will fade in 3-7 days. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I will inform my Acupuncturist if I have any condition and/or taking any medication that interferes with blood clotting.

Herbal Remedies: Herbal formulas (which are from plant, animal and mineral sources) that have been recommended are considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, headache, diarrhea and tingling of the tongue. I will notify my Doctor of Acupuncture, who is caring for me, if I experience any of the above-mentioned side effects or if I become pregnant.

Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your acupuncturist has had training in Clean Needle Technique and Universal Precautions.

I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels, based on the facts then known, is in my best interests. I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have also had the opportunity to ask questions about its content of this consent form, 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.

I understand that any treatment provided by the Acupuncturist when requested without a Chiropractic preliminary exam/ assessment is separate and distinct from the practice of Chiropractic provided by the Doctors of Beacon Hill Chiropractic & Massage. I hereby waive all liability towards the above mentioned chiropractors directly or indirectly associated with Beacon Hill Chiropractic and Massage should any injury or malpractice occur from any treatment provided by the acupuncturist.

Cancelation policy: I understand that if I do not give 24 hours notice upon canceling or rescheduling an appointment I will be charged the following cancellation fees:

1st time - warning
2nd time - 100% of fee.

Please sign and date below to indicate that you have read and understand this form.

_____
Patient Signature (or guardian if patient is under the age of 18)

_____ _____
Patient Printed Name **Date**

_____ _____
Doctor of Acupuncture signature **Date**