Power Health Chinook

Chiropractic, Acupuncture and Massage Therapy

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

❍ Single ❍ Married ❍ Widowed ❍ Separated ❍ Divorced Number of Children: _____

Date of Birth (MM/DD/YYYY) _____ Age: _____ Gender: ❍ Male ❍ Female

Alberta Health Care Number: _____

Phone Numbers: Home _____

Business _____

Cell _____

Email Address: _____

Would you like email reminders for appointments? ❍ Yes ❍ No

Would you like to receive our Monthly Health Tips by email? ❍ Yes ❍ No

Spouse/ Partner: _____

In case of emergency, whom should we notify? _____

Relation to you: _____ Contact number: _____

Your Occupation: _____ Employer: _____

Do you have extended health coverage? ❍ Yes ❍ No

Insurance company: _____

REFERRAL INFORMATION

How were you referred to us?

❍ Personal Referral: _____ ❍ Internet

❍ Physiotherapist ❍ Location

❍ Massage Therapist ❍ Family Physician: _____

❍ Other: _____

If you weren't referred, how did you hear about us? _____

What are the most important health concerns for which you are seeking treatment?

1. _____
2. _____
3. _____

Have you ever had surgical implants or piercing (medical or cosmetic)? ❍ Yes ❍ No

If yes, please list: _____

_____

_____

_____

_____

Have you ever experienced any of the following conditions?

❍ AIDS ❍ Cancer ❍ Diabetes ❍ Hypertension ❍ Allergies

❍ Seizure Disorder ❍ Bleeding Problems ❍ Hepatitis ❍ Heart Disease

Do you currently have any of the following conditions?

❍ Cold/Flu ❍ Infection/Inflammation ❍ Pregnancy/Lactation

What would you say about your diet? ❍ Needs significant improvement ❍ Okay for now ❍ Very healthy

Are you wearing an electronic device? ie. cardiac pacemaker, hearing aid, etc. ❍ Yes ❍ No

Do you have a history of injuries or surgeries? If yes, please list below:

1. _____
2. _____
3. _____

Have you ever tried Chinese Acupuncture and herbal medicine before? ❍ Yes ❍ No

Do you have a large fear of needles? ❍ Yes ❍ No

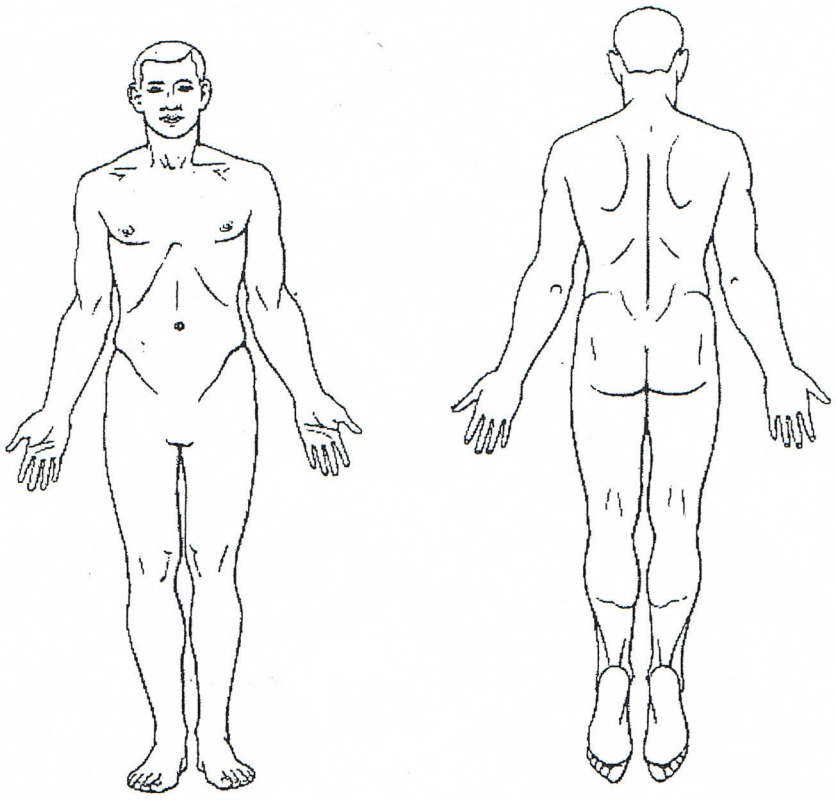
Have you ever fainted because of needles? ❍ Yes ❍ No

Pain Drawing

Name: _____ Date: _____

Using the following symbols, draw the location of your pain on the body outlines below.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^^	========	0000000000	.....	//////////	xxxxxx
^^^^^	========	0000000000	.....	//////////	xxxxxx



Please circle the number that best describes the questions being asked.

1. What is your pain right now?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

2. What is your pain level at its best? (Zero being the best)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

3. What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its worst? (Ten being the worst)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Power Health Chinook

Patient Medication History Form

Patient name:_____

Allergies:

Name of substance	Type or reaction
○ **None**	

Do you react to latex or rubber (gloves, balloons, etc.) with a rash, wheezing? Yes___ No____

For female patients ONLY: Are you currently pregnant? Yes___ No____

Are you considering becoming pregnant? Yes___No____

Are you currently breastfeeding ? Yes___No____

Current Medications:

Prescription Drugs	**Dosage**	**Directions**	**Checkmark if taken as needed**
○ **None**			
			○
			○
			○
			○
			○
			○
Over the counter medications(i.e. Tylenol)			
○ **None**			
			○
			○
			○
			○
			○
Herbs, vitamins, Minerals etc.			
○ **None**			
			○
			○
			○

Acupuncture Consent Form

I, _____, voluntarily consent to be treated by **Jennifer Nelson, TCMD, R. Ac., PTA.** I intend this consent to apply to all my present and future acupuncture and TCM treatments.

I am aware that certain side effects may result from my treatment. These include, but are not limited to some local bruising, bleeding, dizziness, fainting, nausea, temporary pain and discomfort, and possible aggravation of symptoms existing prior to the treatment. On rare occasions pneumothorax, or a broken needle may occur.

I accept that no guarantee is made concerning the results of my acupuncture treatments and I have been informed that I may stop at any time. Jennifer Nelson is not liable for any of the above side effects that may occur. The risk of injuries or complications from acupuncture treatments is substantially lower than that associated with many medical or most other treatments, medications and procedures for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my acupuncturist the nature and purpose of my treatment and the contents of this Consent form.

I understand that there will be a $50 cancellation fee for appointments that are not cancelled 24 hours prior to the appointment date.

Dated this _____ day of _____, 20_____

_____ _____

Patient Signature (or Legal Guardian) **Witness of Signature**

Name: _____ **Name:_____**

(please print) **(please print)**