Victoria Exercise Rehabilitation Centre Ltd.

"Strength, mobility and confidence"

PERSONAL INFORMATION

Name: _____ DOB (day/month/year): _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell #: _____

Email:

_____

Emergency contact: _____ Contact #: _____

Relationship: _____

ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE HISTORY

Please check off the services that you have received before:

- □ Acupuncture
- □ Chinese Herbs
- □ Cupping
- □ Gua Sha
- □ Tui Na
- □ Moxibustion

REASON FOR VISIT

Please list the major health concern(s) in the order of importance and the date it started:

1. _____
2. _____
3. _____
4. _____

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Have you been treated by any other health professionals for this health concern? Please list any diagnosis and treatment protocols that you have been given.

_____

_____

_____

MEDICAL HISTORY

Please list all medications and supplements that you are currently taking and list the condition(s) that you are taking them for:

_____

_____

_____

Please list any surgeries that you have undergone, including the year performed.

_____

_____

Do you have any allergies? □ Yes □ No If yes, please list:_____

_____

Please list any significant health concerns that your family members have experienced?

_____

_____

Do you have a pacemaker? □ Yes □ No
Are you pregnant? □ Yes □ No

Please check off any of the following conditions that you have:

□ Bleeding condition
□ Chronically impaired immune system
□ Extreme Fatigue
□ Hepatitis
□ HIV
□ History of seizures
□ Low or high blood pressure
□ Other infectious disease _____

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INFORMED CONSENT

As a patient of Victoria Exercise Rehab Centre, I confirm that I have provided all necessary information for my practitioner to fully comprehend my medical history, including physical and emotional conditions and medications. I understand that it's my responsibility to update my practitioner if there are any changes in medical diagnosis and medications.

I understand that acupuncture/traditional chinese medicine is not a replacement for conventional medicine diagnosis and treatment provided by an MD. I am informed that chinese medicine practitioners do not diagnose diseases and do not prescribe medications.

The risks of acupuncture and other Traditional Chinese Medicine modalities (bodywork, cupping, electric acupuncture, guasha, moxibustion) include, but are not limited to, skin irritation, bruising, pneumothorax, blistering, fainting, injury, aggravation of preexisting symptoms and allergic reactions to herbs with medications.

I will communicate with the acupuncturist if I experience pain or discomfort during the treatment in order for the treatment to be modified to best suit my needs.

I have read the above information and give my consent to all of the above for the entire duration of treatment at Victoria Exercise Rehab Centre. I understand that I am free to withdraw my consent at any time. I have had the opportunity to ask any questions that I have about this form's content.

CANCELLATION

I agree to give 24-hours notice to change or cancel my appointment. Otherwise, I will expect to be charged the full treatment fee.

TO BE COMPLETED BY THE PATIENT

_____ _____

SIGNATURE OF PATIENT (or parent/guardian) PRINT PATIENT'S NAME

_____ _____

DATE SIGNED WITNESS