

Harbour City Healers

Acupuncture Intake Form for Addiction Treatments

Information for your Acupuncturist
All information is strictly confidential.

Important: Complete this document as thoroughly as possible.

Patient Information

Date: ____/____/____

Name: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____

Province/Country: _____ Postal code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Age: ____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____ Height: ____' ____" Weight: ____ lbs

Emergency Contact Name: _____ Phone: (____) _____

E-mail: _____ Receive e-mail communications? ☐ Yes ☐ No

Occupation: _____ Retired: ☐ Yes ☐ No Year Retired _____

Extended Coverage: ☐ Yes ☐ No Provider? _____

MSP Premium Assistance (low income): ☐ Yes ☐ No Care Card #: _____

Have you had Acupuncture before? ☐ Yes ☐ No Last treatment? _____

How did you find us or who referred you? _____

Please list any addictions, in order of significance to you:

Addiction & Date Started

Details about Addiction

1. _____
2. _____
3. _____

What are your goals? _____

Do you have any concerns with the following **areas/symptoms**:

☐ Pain, if so where? _____

☐ Headaches/Migraines ☐ Dizziness ☐ Memory/Concentration ☐ Cardiovascular

☐ High/Low Blood Pressure ☐ Respiratory ☐ Depression ☐ Anxiety ☐ Sleep

☐ Digestion ☐ Bowel Movements ☐ Urination ☐ Appetite/Thirst

☐ Fertility ☐ Pregnancy ☐ Libido ☐ Menstruation/PMS ☐ Impotence

☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Mouth ☐ Sweating ☐ Skin ☐ Hair ☐ Body

☐ Other: _____

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Informed Consent for Acupuncture Treatment

By signing below, I hereby agree and consent to the performance of acupuncture and other TCM procedures. I understand that such procedures may include, but are not limited to acupuncture, manual and electrical stimulation, massage, fire cupping, gua-sha, acupressure, blood letting, infrared heat lamp, and nutritional counseling.

Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments. Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. I have been informed that in all acupuncture treatments only pre-sterilized, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

The Potential Benefits: Acupuncture may allow for the 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/ailments.

The Potential Risks: I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including slight pain or discomfort in the area of needle insertion, bruising, numbness or tingling, minor swelling, bleeding, infection, weakness, hematoma may occur at the site of insertion and may last a few days, fainting, dizziness and nausea. A sensation of light-headedness may occur after acupuncture treatment. Electro-acupuncture should not be used on patients who have a history of seizures, epilepsy, heart disease or strokes, or over a pacemaker. Blood letting procedure may cause pain, discomfort and bruising. Cupping can leave temporary bruised painful marks on the skin and there is also a small risk of burns or blisters. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I will immediately notify the acupuncturist if I experience any problems.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture is not a substitute for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I understand the clinical and administrative staff may review my patient records but all my records will be kept confidential and will not be released without my written consent. I understand that it is my responsibility to inform the practitioner of all current medications, herbs and supplements that I take.

In addition I will inform the practitioner of any **pace makers, artificial implants, addictions, and allergies** I have as they may affect the treatment plan. I state that I do not have the following conditions: **pregnancy, blood-borne diseases, local infections, bleeding disorders or taking anticoagulants**. If I have any of the above conditions, I have listed them here: _____

By voluntarily signing below, I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Patient

Signature of Patient

Signature of Practitioner

Date Signed: ____/____/____