

517 WENTWORTH STREET
NANAIMO

250.797.0973



DATE: _____
TIME: _____
CHART #: _____

PERSONAL INFORMATION	CONTACT INFORMATION
Name _____ Birthdate _____ MSP/Care Card # _____ Occupation _____ How did you hear about us? _____	Address _____ _____ Home phone _____ Mobile phone _____ Email _____
HEALTH HISTORY	
What are your primary concerns for treatment? 1- _____ _____ 2 - _____ _____ 3 - _____ _____ 4 - _____ _____ How is your sleep? _____	Please list any relevant history, allergies & alerts _____ _____ _____ _____ Current medications & treatment _____ _____ _____ _____ _____
OFFICE USE	
Notes: _____ Instructions: _____	

INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I understand that acupuncture is a generally safe, natural method of healing and I recognize the potential risks and benefits of these procedures as described below.

POTENTIAL RISKS: Although uncommon, there is a potential for acupuncture to cause temporary bruising or bleeding, swelling, numbness, tingling, and soreness at the needle site that may last a few days. Rare side effects can include dizziness, fainting, or possibly the aggravation of pre-existing symptoms. Infection is a slight possibility even though our clinic uses only single use, disposable needles and maintains a clean and safe environment.

HEALTH ALERTS: Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum care. However, some acupuncture points are contraindicated during pregnancy as they may cause premature labor. Other health conditions have a bearing on treatment given including heart conditions, diabetes or if you suffer some specific infections and illnesses. Please notify your acupuncturist if you become pregnant (or are trying to get pregnant) or suffer any relevant health conditions.

MSP & PREMIUM ASSISTANCE: I understand that the information provided will be used to check my eligibility for government coverage and for direct billing for acupuncture service. If eligible for coverage, up to ten visits per year will be billed to the province and I will not be asked for additional payment for these visits.

PRIVACY: Since several people are being treated in the same room at once it is vital that we work together to respect your privacy and the privacy of others. Let us know if there are certain topics that need extra discretion or if you prefer to do your intake in a more private setting.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I acknowledge my understanding and agree to treatment. 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. The information I provide is true and complete to the best of my knowledge,

Signature (or guardian)

Date

Name (or guardian)

Practitioner