STEVEN ENMAN-BEECH
traditional acupuncture

Date (DD) (MM) (YYYY)

Legal Name

Preferred Name

Date of Birth (DD) (MM) (YYYY) Gender

PERSONAL INFORMATION

Please check here if you do NOT wish to receive email updates ☐

Phone # Email

Address Apt #

City Province Postal Code

Emergency Contact Emergency Phone #

Physician Physician Phone #

MAIN CONCERN/REASON FOR VISIT

When did it start? What makes it better or worse?

HEALTH HISTORY (if you need more space, please ask for a second form!)

Major illnesses you have had

Major illnesses in your family

Medications you are taking	for what conditions	when you started

Allergies

List all surgeries, injuries, traumas and date

Other treatments you are presently receiving

LIFESTYLE AND HABITS

Please list any special dietary habits and years

(e.g. vegetarian, vegan, raw, etc)

Do you consume and how often/how much

Coffee

Tea

Alcohol

Soda

Tobacco

Other

Sports, Physical Activity and how often

Energy Level (from 1 to 10)

Do you feel (please mark on the scale)

Cold — Hot

PLEASE CHECK OR FILL IN ALL THAT APPLY. (C) for "Chronic" and (R) for "Recent"

Check “C” for Chronic, recurring or long-standing problems that you may or may not be experiencing now.

Check “R” for Recent problems that you are experiencing at the moment, or have experienced very recently.

C R MUSCULOSKELETAL

- ☐ ☐ Neck
- ☐ ☐ Back
- ☐ ☐ Knee / Leg
- ☐ ☐ Shoulder / Arm
- ☐ ☐ Hand / Wrist
- ☐ ☐ Foot / Ankle
- ☐ ☐ Scoliosis
- ☐ ☐ Bursitis
- ☐ ☐ Tendonitis
- ☐ ☐ Sciatic Pain
- ☐ ☐ Arthritis
- ☐ ☐ TMJ
- ☐ ☐ Degenerating disc disease
- ☐ ☐ Osteoporosis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chronic fatigue

HEAD EYES EAR NOSE & THROAT

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Dizziness
- ☐ ☐ Vision problems
- ☐ ☐ Ear problems
- ☐ ☐ Loss of smell
- ☐ ☐ Dry Throat Sore
- ☐ ☐ Throat

RESPIRATORY

- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Asthma and Wheezing

C R CARDIOVASCULAR

- ☐ ☐ Pacemaker
- ☐ ☐ High Blood pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Heart attack / Stroke / CVA
- ☐ ☐ Varicose / Spider veins
- ☐ ☐ Fainting
- ☐ ☐ Hemophilia

GASTROINTESTINAL

- ☐ ☐ Ulcers
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Crohn's or Ulcerative Colitis
- ☐ ☐ Nausea
- ☐ ☐ Gallstones / Cholecystitis

DERMATOLOGICAL

- ☐ ☐ Itching
- ☐ ☐ Rashes
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Plantar warts
- ☐ ☐ Sensitive skin
- ☐ ☐ Bruise easily
- ☐ ☐ Dry Skin / Scalp

GYNECOLOGICAL

Currently pregnant ☐

How many months _____

# of pregnancies_____

First period year _____

Menopause year _____

Final period year _____

Period duration _____

Cycle duration_____

- ☐ ☐ PMS
- ☐ ☐ Irregular periods
- ☐ ☐ Painful periods
- ☐ ☐ Light periods
- ☐ ☐ Heavy periods
- ☐ ☐ Fibroids
- ☐ ☐ Endometriosis
- ☐ ☐ Infertility
- ☐ ☐ Low sexual drive
- ☐ ☐ High sexual drive

C R ANDROLOGICAL

- ☐ ☐ Difficult ejaculation
- ☐ ☐ Painful ejaculation
- ☐ ☐ Premature ejaculation
- ☐ ☐ Involuntary seminal emission
- ☐ ☐ Low sexual drive
- ☐ ☐ High sexual drive

URINARY

- ☐ ☐ Difficult urination
- ☐ ☐ Painful urination
- ☐ ☐ Frequent urination
- ☐ ☐ Kidney stones
- ☐ ☐ Kidney disease
- ☐ ☐ Urinary tract infection (UTI)

PSYCOLOGICAL & NEUROLOGICAL

- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Poor Sleep
- ☐ ☐ High Stress level
- ☐ ☐ Low Stress Level
- ☐ ☐ Seizures
- ☐ ☐ Transient Ischemic Attack (TIA)
- ☐ ☐ Epilepsy

OTHER

- ☐ ☐ Loss of sensation
- ☐ ☐ Loss of balance
- ☐ ☐ Edema / Swelling
- ☐ ☐ Cancer (Past or Present)
- ☐ ☐ Hepatitis
- ☐ ☐ Sensitivities
- ☐ ☐ Diabetes
- ☐ ☐ Tuberculosis
- ☐ ☐ HIV
- ☐ ☐ STD/STI
- ☐ ☐ Surgical implants
- ☐ ☐ Pins, Wires, Plates
- ☐ ☐ Electronic Medical Devices (EMD)
- ☐ ☐ Prostheses

Others

_____

_____

_____

_____

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Informed Consent to Treatment

Before any treatment, it is necessary for any health care provider to inform their patient of the procedures and treatment expectations, and to receive from the patient their informed consent to treatment. It is essential that you understand the services provided, their effects, the price involved, and what is done with personal information. If you have any questions regarding any of this, please do not hesitate to ask.

I, or the person listed below, have discussed with my Acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine/Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, guasha, and tuina massage. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.

2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.

3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.

4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious

agents, including but at not limited to Hepatitis, HIV, and Tuberculosis (TB). In some cases where cross-infection is high, my practitioner may withhold treatment.

5. I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.

6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered. Services are payable in cash, personal cheques or credit card. If I need to cancel my booking I shall give at least 24 hours notice. **Missed appointments, showing up for an appointment more than 15 minutes late, and appointments canceled with less than 24 hours notice will be charged a $25 fee payable at the next visit.** Late arrivals may be accommodated if there is space, at the discretion of the Acupuncturist.

7. I understand that in accordance with PHIPA (Professional Health Information Protection Act) the personal information collected at this clinic (contact, family, medical history, medical insurance and billing/account information) is confidential, but it can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law.

8. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

_____	_____	_____
Print Name of Client/Guardian	Date	Signature

In place of a digital signature, please check this box to confirm that you have read and understood the above consent to treatment form ☐