Acupuncture Health History

General Contact Information

Name:		Date of Birth:
Address:	City:	Postal Code:
Contact Numbers#:	Home #:	Work #: Cell #:
Email: (By checking you give David E. Chung Permission to email you as a form of communication)		Email address:
Occupation: (Retired)		Referred By:
Family Physician:		MD Number#
Emergency Contact:		Contacts Number #

Insurance Information

Have you check your plan to see if you are covered for Acupuncture?	
Insurance Company:	

Acupuncture Care?

Have you been treated with Acupuncture before?	Yes/ No	When?
What concerns were you treated for?		
Who performed the Acupuncture treatment?	Registered Acupuncturist Physiotherapist Chiropractor Medical Doctor Naturopathic Doctor Massage Therapist	

Which Therapies have you tried in the past or are currently using?

Acupuncture	Chiropractic	Naturopathic Medicine	Physiotherapy
Registered Massage	Personal Trainer	Nutritionist	Chiropodist
Homeopathy	Psychotherapy	Other:	

Please describe your concerns you would like help with.		Pain Scale 1-10
Please list your primary concern:		
What is your Secondary concern?		
When did it begin? (Years, Months, Weeks)		
What makes it worse?		
What makes it better?		

Do these problems interfere with your daily activities?			
Work	Sitting	Relationship	Sexually
Sleep	Standing	Social Life	Recreational
Walking	Emotionally	Stretching	Bending
Lying down	Running	Other:	

Previous Injuries and Accidents:		
List Surgeries: (As far back as you can recall.)		
List Trauma's, Accidents, Previous Injuries etc.	1. 2. 3. 4.	When: When: When: When:
List activities you are involved in:	1. 2. 3. 4.	

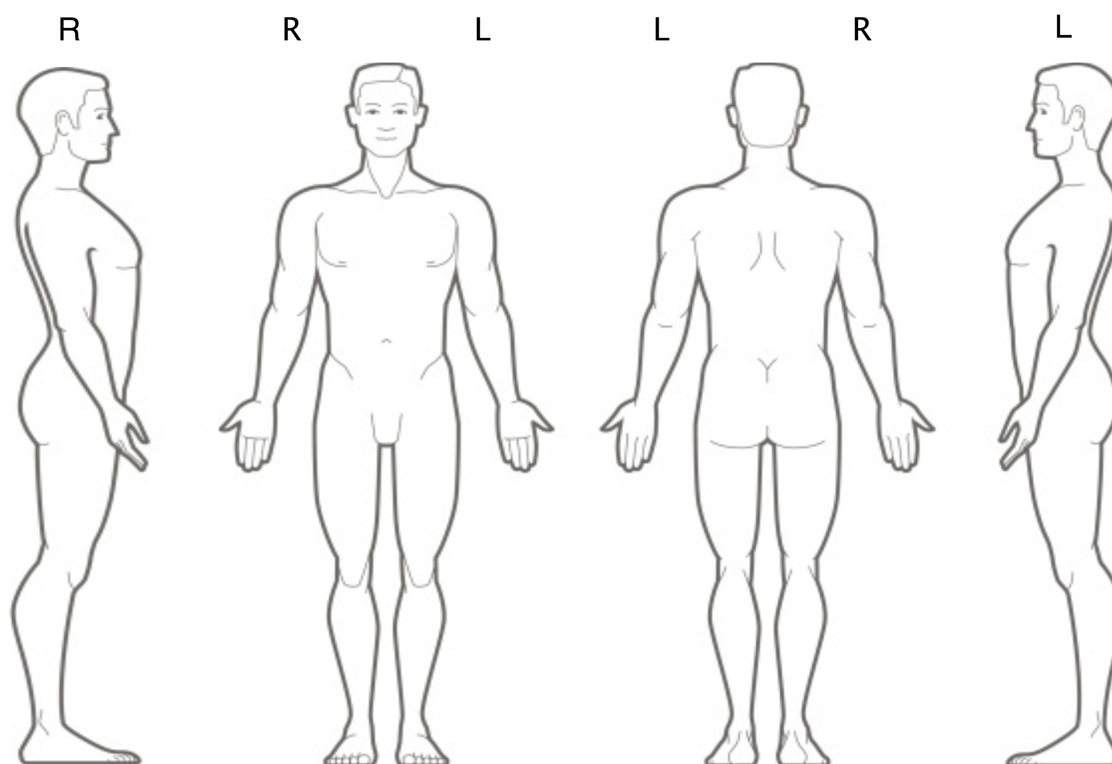
Female Concerns:		
Date of last menstruation:		Is your cycle regular? Yes/ NO
Have you ever been pregnant? Yes/ No		

Physical Health	
What is your current state of physical health:	Very Poor, Poor, Good, Great
What is your current diet consist of?	

Medical History:		
Do you have any allergies? Yes/ No	If so, to what?	
Please list all medications:	– – – –	for: for: for: for:
Please list all supplements/ Vitamins:	– – – –	for: for: for: for:

Please indicate if you or any family members have or had any of these following concerns.				
Pneumonia	Drug Reaction	Mental Breakdown	Herpes	Mental Illness
Tuberculosis	Heart Attack	Blood Transfusion	Aids	Hyper-Thyroid
Hepatitis	Jaundice	Blood Pressure	Parasites	Hypo- Thyroid
Diabetes	Anemia	Measles	Mumps	Premature Grey
Epilepsy	Arthritis	Heart Disease	Gout	Seizures
Kidney Stone	Obesity	Syphilis	Cancer	Multiple Sclerosis

Please Indicate the areas of discomfort:



Lung and Large Intestine (Please check mark all of the concerns that relate to your health)			
Allergies	Flatulence	Smelling Difficulties	Elbow Pain
Arm/ Shoulder Pain	Frequent Colds	Excessive Sweating	Fatigue/ Tired
Constipation	Frontal Sinus Headache	Stiff Joints/ Neck	Nasal Problems
Cough/ Phlegm	Sad/ Grief	Weak Voice	Sinusitis
Eczema/ Psoriasis	Loose Stool	Wheezing	Mucus

Kidney and Bladder (Please check mark all of the concerns that relate to your health)			
Adrenal Weakness	Dark Puffy around eyes	Lack of Stamina	Sciatica
Back/ Hip/ Knee Pain	Depression /Fear	Lethargy/ Fatigue	Senility
Bladder Infection	Edema/ Water retention	Loss, Thinning hair	Sore Throat
Brittle Bones	Impotence	Poor Memory	Tinnitus
Cold Hands, Feet	Infertility	Premature Grey	Low will power

Liver and Gall Bladder (Please check mark all of the concerns that relate to your health)			
Anger/ Irritable	Depression	Hemorrhoids	Nausea/ Vomiting
Blurry Vision/ Spots	Distention/ Bloating	Indigestion	Tinnitus High Sound
Breast Tenderness	Vision Problems	Irritable Bowel	Menstrual Irregularities
Bruising Easily	Flatulence	Stiff Neck	Headache/ Migraines
Eczema/ Psoriasis	Stiff Shoulders	PMS	Tension/ Spasm/ Cramps

Heart and Small Intestine (Please check mark all of the concerns that relate to your health)			
Abdominal Pain	Elbow/ Shoulder Pain	Insomnia	Poor Circulation
Anemia	Hearing Problems	Lack of Joy	Mouth/ Tongue sores
Anxiety	Heart Problems	Restless	Sleep Problems
Digestive Troubles	Hot Flashes	Urinating Problems	Upper Back Pain
Dream Disturbances	Hot Painful Joints	Palpitations	Tongue/ Speech problems

Spleen and Stomach (Please check mark all of the concerns that relate to your health)			
Abdominal Pain	Bruise Easily	Gastritis	Loose Stool
Anemia	Indigestion	Headaches	Muscle Weakness
Aching/ Heavy Limbs	Poor Focus	Hiccups	Nausea Vomit
Digestive Troubles	Distention/ Bloating	Irritable Bowel	Poor Memory
Belching	Dyspepsia	Fatigue	Worry Over thinking

Patient Informed Consent to Treatment

Registered Acupuncturist David E. Chung R.Ac

Justine Blainey Wellness Centre
220 Wexford Rd. Brampton Ontario
office # (905)840-9355 Fax: 905840-5433

I,________________________________ have discussed with David E. Chung R.Ac the specifics of my assessment or treatment and understood the nature, risks and reason for this procedure. I voluntarily consent to be treated with Acupuncture and understood that I may withdrawal 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, Cupping or and Tui'na.** 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 David E. Chung R.Ac has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight, light-headaches to nausea, soreness, bruising, minor bleeding around needle site 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 David E Chung R.Ac, **if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorders, or if I use a pacemaker.**

4. I understand that I must let David E Chung R.Ac know **if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB, and Hepatitis.** In some cases where cross infection is high, David E. Chung 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 treatments 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 **$85 Initial Fee and $75 Subsequent/ $60 For Seniors visit fee** charged for my treatments are not covered under OHIP and must be paid in full at the time of service. I am responsible for the full and prompts payment after services have been rendered.

7. I have discussed the consent of this form with David E. Chung R.Ac. I acknowledge that I have asked questions and have received answers I understand. By signing this form, I give my informed consent to receive Acupuncture, Acupressure or Cupping treatments.

(Check) I consent to be treated By David E. Chung with Acupuncture.		
I, Please Print name:	Consent to care on:	(DD/MM/YY)
Signature Here:		Initialed by David E. Chung