Dr. Karen Brust

Dr. Marcia Scott

Dr. Janine Schuler

Name______________________________________Date____________________

Date of Birth__________________________ (M/D/Y) Sex: M F

Address____

City________________Province__________________Postal Code________________

Phone (H) _______________ (Cell) __________________ (W) ________________

Email____

Check if you would like to receive:

☐ Appointment Reminder ☐ Health Tips/Newsletter ☐ Specials

Emergency Contact Name_________________________Phone____________________

Who referred you/ How did you hear about us? ______________________________

What is the goal of your visit today? ____________________________________

____

Medical History

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Occupation__________________________Hobbies_____________________________

Do you exercise regularly? Y / N What do you do, how much and how often? ____________

____

Average hours of sleep per night __________ Do you wake refreshed? ______________

Energy levels (average, circle) Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Stress levels (average, circle) Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Please indicate any serious conditions, illnesses, injuries and any hospitalizations (with dates)

____

____

Current medications and supplements (prescription, over counter, vitamins, supplements etc.)

____

When was the last time you were treated with antibiotics? ____________________________

Do you get regular screening tests done by your doctor? (Pap, Blood tests etc.) Y / N

If you are female, are you currently pregnant? Y / N Trying to get pregnant? Y / N

Check if you have experienced any of these symptoms

_Poor appetite _Night sweats _Rashes _Eczema

_Cravings _Chills _Hair loss _Warts

_Strong thirst _Fever _Acne _Bleed/Bruise easily

_Headache _Blurry vision _Earaches _Dizziness

_Neck pain _Eye pain _Ringing ears _Fainting

_Concussion _Jaw pain _Sinus problems _Chest pain

_High blood pressure _Irregular heartbeat _Difficulty breathing

_Low blood pressure _Blood clots _Asthma

_Cold hands/feet _Varicose veins _Coughing blood

_Indigestion _Constipation _Hemorrhoids _Impotency

_Gas/Bloating _Diarrhea _Pain or urgency with urination

_Abdominal pain _Nausea/Vomiting __# of bowel movements/day

Women Only ____Number of pregnancies ____Number of births

_Irregular periods _Painful periods _Heavy flow _Light flow

If you use birth control: What type_______________ How long____________________

_Depression _Poor memory _Areas of numbness

_Anxiety _Loss of balance _Lack of co-ordination

Have you ever been treated for psychological issues? ____________________________

Patient Confirmation of Consultation Form & Waiver

Section 8(1) of Alberta's Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless:

(a) That a person has already consulted with a physician or, in the case of dental pathology, a dentist about the condition for which treatment from the acupuncturist is being sought;
(b) That person has informed the acupuncturist that a physician or dentist has been consulted about the condition;
(c) The acupuncturist has completed a patient consultation form.

Has the patient consulted with a Physician or Dentist (as appropriate) about the condition for which acupuncture treatment is now being sought?

______ Yes ______ No

I, ________________________________(print name) hereby authorize and grant permission to my health care provider to carry out such examinations, procedures, and treatments as deemed necessary or as ordered by my physician.

I _______ (initial) am informed that no procedure will be conducted without full explanation of the reason or method relating to the procedure and advice of risks such as:

- fainting
- small bruises
- bleeding
- post - acupuncture sensation (numbness, tingling, heaviness, and tiredness)
- temporary exacerbation of symptoms

I, ______ (initial) hereby acknowledge and understand that I am personally liable for any cost incurred by myself at Acupuncture Plus (#A306 1600-90 Ave SW Calgary, AB) under Dr. Karen Brust, Dr. Marcia Scott and Dr. Janine Schuler.

I, ______ (initial) hereby acknowledge and understand we require 24 hours' notice of appointment cancellation. Any appointments cancelled with less notice will result in a full charge for the session missed.

______________________________	______________________________
Patient Signature	Date
Witness Signature	Date
Parent/ Guardian Signature	Date