Passage Wellness & Acupuncture

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Date:_____

Name:_____ Preferred Name:_____

Address:_____City:_____Prov:_____Postal_____

Best Phone:_____Email:_____

Okay to contact by phone: ◯ Yes ◯ No Okay to contact by email: ◯ Yes ◯ No

Date of Birth: _____ Age: _____ Preferred Pronoun: _____

Gender: ◯ Female ◯ Male
◯ Transgender: ◯ Trans Man ◯ Trans Woman
◯ Non-binary ◯ Gender-non-conforming ◯ Other: _____
◯ Prefer not to say

Occupation (if applicable):_____

Personal Health Number: _____

Medical Doctor:_____

Emergency Contact Information:
Name: _____
Phone: _____
Relationship to patient: _____

Have you had acupuncture previously? Yes ◯ No ◯

How did you hear about me?_____

Operations, injuries, surgeries:

Allergies, drug reactions:

Medications, Herbs, Supplements, Vitamins, etc.:

Health History:

Please indicate if you have, or have had, the condition and the year it started.
If there is family history, indicate with an "F":

- ▫ Bleeding disorder
- ▫ Anemia
- ▫ Diabetes
- ▫ Asthma/allergies
- ▫ High blood pressure
- ▫ Low blood pressure
- ▫ Heart Disease
- ▫ Pacemaker
- ▫ Stroke
- ▫ High cholesterol
- ▫ Osteoporosis
- ▫ Arthritis

- ▫ Thyroid conditions: hyper/hypo
- ▫ Autoimmune: type: _____
- ▫ Cancer: type: _____
- ▫ Substance abuse
- ▫ Depression/Anxiety
- ▫ Seizure disorder

Communicable/Infectious diseases:
Do you have a blood borne disease or any communicable/infectious diseases:

Yes ◯ No ◯
If so, please indicate: _____

Main Complaint:

_____

How long have you experienced this issue: _____

Intensity: MILD 0----1----2----3----4----5----6----7----8----9----10 SEVERE

What makes this issue better? (temperature, movement, medications, other treatments, etc.)

_____

What makes this issue worse? (temperature, movement, medications, other treatments, etc.)

_____

Does this issue interfere with your:
Work? Yes ◯ No ◯ Activity/exercise? Yes ◯ No ◯
Sleep? Yes ◯ No ◯ Relationships? Yes ◯ No ◯

Secondary Complaint:

_____

How long have you experienced this issue: _____

Intensity: MILD 0----1----2----3----4----5----6----7----8----9----10 SEVERE

What makes this issue better? (temperature, movement, medications, other treatments, etc.)

_____

What makes this issue worse? (temperature, movement, medications, other treatments, etc.)

_____

Does this issue interfere with your:
Work? Yes ◯ No ◯ Activity/exercise? Yes ◯ No ◯
Sleep? Yes ◯ No ◯ Relationships? Yes ◯ No ◯

How do you sleep? (*trouble falling or staying asleep, dreams, waking often- at specific times, etc.*)

_____

How is your digestion? *(appetite, bloating, nausea, heart burn, etc.)*

_____

How often do you move your bowels?_____With ease?_____

Do you feel like you have enough energy to get through the day?_____

Do you get regular exercise? If so, explain: _____

Please rate your current stress level:

MILD 0----1----2----3----4----5----6----7----8----9----10 SEVERE

Generally, the emotions you feel on a daily basis are (circle all that apply):

Content Joy Sad Depression Anxious Fearful Irritable Angry

Is there anything else you'd like me to know about?

_____

_____

_____

Consent to Treatment

I, or the person listed below, understand that acupuncture and its adjunctive therapies are safe, natural methods of healing and I am aware of the potential risks and symptoms of these procedures. These 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 procedures.

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

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. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB, and Hepatitis.

I understand there are no guarantees for the result of treatments. Acupuncture does not provide an instant cure. The length of my treatment course can depend on the severity of my condition. In some cases, my symptoms may temporarily worsen before they begin to improve.

I voluntarily consent to Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

24 Hour Cancellation Policy

I am responsible for the full and prompt payment of my treatments. I agree to pay the full fee for any treatments missed or cancelled without 24 hours prior notice.

By signing below, I consent to be treated with acupuncture by Jenica Geisler.

I understand that Registered Acupuncturists practicing in the province of British Columbia are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Signature: _____ **Date:**_____