eastman
THERAPY CENTRE

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ACUPUNCTURE INTAKE FORM

PATIENT INFORMATION

First Name: _____Last Name: _____

Address: _____ City: _____ Postal Code:_____

Date of Birth (DD/MM/YY): _____ Email Address: _____

Phone Number: *Home* _____ *Cell* _____ *Other* _____

Preferred Method of Appointment Reminder *(Circle One)* Phone *or* Email *or* Text

Occupation: _____ Employer: _____

Do you have extended health insurance (benefits)? Yes / No

If "Yes", which company? _____ Policy/ ID Number _____

Emergency Contact: _____ Relationship: _____

INJURY INFORMATION

Each appointment is based upon one injury claim per session.

Injured body area: _____ Approx. date of injury:_____

Is this a recurring injury/issue? YES NO

Please read the entire write-up and fill out all the information in full.

- Please be on time for your appointments. If you are going to be late, all we ask for is a phone call prior to the appointment. This will help us to adjust our schedule accordingly. Being late by more than 15 minutes may require your appointment to be rescheduled.
- Cancellations require 24-hour notice. We understand life happens and we will try to be as understanding as possible. If cancellations without proper notice occur, a $30 fee will be added to your next appointment.
- A physician's referral is not required for you to attend our clinic, but it may be required for your insurance coverage. It is your responsibility to determine the details of your insurance coverage. If coverage is denied, you are responsible for any costs.
- Manitoba Health does not cover any of the costs of treatment.
- Please inquire about our direct billing to private insurance companies. We do direct bill to MPI and WCB for claims.
- It is your responsibility to provide us with your MPI or WCB claim number. You must pay for MPI and WCB claims only if the claim is denied.
- There may be discomfort experienced throughout the therapy process. Everyone's body reacts differently to treatment and occasionally people will feel sore and tender. Inform your therapist if you experience discomfort.

ACUPUNCTURE CONSENT

"Acupuncture" means the stimulation of a certain point or points near the surface of the body via the insertion of thin needles. The purpose of acupuncture is to present or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, is also often serves in the treatment of certain diseases or dysfunctions of the body.

Potential benefits: Acupuncture may allow for the painless relief of one's symptoms without the need for drugs. It can also improve the balance of bodily energies leading to the prevention of illness or elimination of the presenting problems.

Potential risks: Slight pain of discomfort at the site of needle insertion, infection, bruising, weakness, numbness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncturing including lung punctures (pneumothorax).

Use of disposable needles: To reduce the possibility of infection from this treatment, all our needles are one-time use, pre-sterilized, and made of surgical stainless steel. After each treatment, they are disposed of as medical waste; needles are never reused. Additionally, your acupuncturist has had training in Clean Needle Technique and Universal Precautions.

To your knowledge, check off any of the following which apply to you:

	YES	NO
Pacemaker	☐	☐
Hemophilia	☐	☐
Fear of needles	☐	☐
Heart valve replacement	☐	☐
Pregnant	☐	☐
Surgery within the past 3 months	☐	☐
Long-term use of anti-inflammatories (steroids or NSAIDS)	☐	☐
Prone to fainting, light-headedness of dizziness	☐	☐
The use of any anti-coagulant/blood thinner medication	☐	☐

I understand that clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I understand that it is my responsibility to inform the practitioner of all current medications, herbs, and supplements I am currently taking. In addition, I will inform the practitioner of any pacemaker, artificial implants, addictions, and allergies I have, as they may affect the treatment plan.

By voluntarily signing below, I show that I have read the above, consent to treatment, have been informed of the benefits and risks of treatment of acupuncture, and have had an opportunity to ask any questions I have. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Client/Guardian signature: _____ Date: _____