Vital Acupuncture & Massage

INITIAL CONSULTATION – CONFIDENTIAL

NAME_____ D.O.B. _____

ADDRESS _____

_____State: _____ Post Code _____

TELEPHONE (H) _____ (W) _____ (M) _____

EMAIL _____ OCCUPATION _____

Can we leave a message if you are not available? Yes No

How did you hear about us? ☐ Doctor ☐ Drive-by ☐ Yellow Pages ☐ Gift ☐ Social Media

☐ Neighbourhood Newsletter ☐ Internet Search ☐ Other _____

Emergency Contact

Name _____ Phone _____ Relationship_____

Medical Details

Health Fund: _____

Name of Doctor: _____ Telephone: _____

Name of Other Health Care Professional treating you:

Are you Pregnant? ☐ No ☐ Yes Weeks pregnant: _____ Any high risk factors?

Please List ALL types of Surgeries you have had in the past (Please Include Dates): _____

_____

Please List ALL Accidents and/or Hospitalizations you have had in the past (Please Include Dates): _____

_____

_____

List ALL Allergies (Food, Medications, Pollen, etc:

_____

List ALL Medications (prescription & over-the-counter, Vitamins & Supplements, Herbs) you are CURRENTLY taking (Please include duration of use & Dosage):

_____

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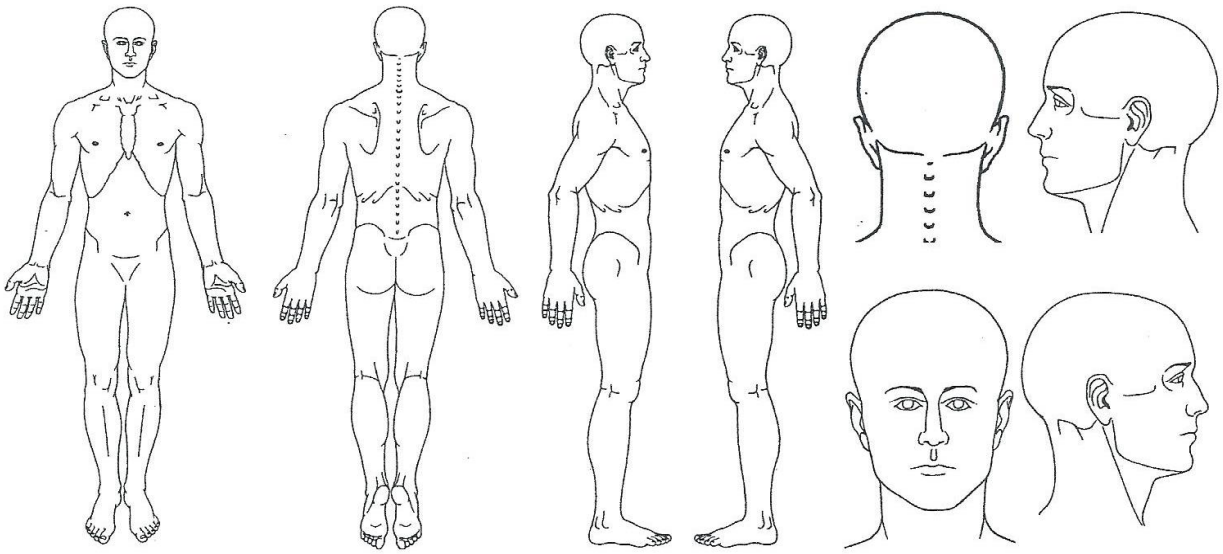
Please indicate any of the following that apply to you.

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Palpitations
☐ Allergies	☐ Chest Pain	☐ Headaches	☐ Paralysis
☐ Anxiety	☐ Diabetes	☐ High Velocity Injuries	☐ Parkinson's
☐ Anaemia	☐ Dizziness	☐ High Blood Pressure	☐ Renal Disease
☐ Asthma	☐ Depression	☐ Low Blood Pressure	☐ Swelling
☐ Autoimmune Disorders	☐ Epilepsy	☐ Joint Replacement(s)	☐ Skin Disorders
☐ Bladder Disease	☐ Fainting	☐ Liver Disease	☐ Stroke
☐ Bleeding Disorders	☐ Fractures	☐ Lung Disease	☐ Sprains or Strains
☐ Blood Clots	☐ Gall Bladder Disease	☐ Muscle Pain	☐ Tuberculosis
☐ Back Pain	☐ Heart Disease	☐ Neck Pain	☐ Tingling / Burning
☐ Bell's Palsy		☐ Numbness	☐ Varicose Veins/DVT

Reason for consultation **MAIN COMPLAINTS**	**Intensity**	
Presenting Conditions and/or Health Conditions you would like to have help addressing. (Please list in the order of importance below)	On a scale of "1 to 10", please rate the intensity of your complaint **(0 + No Discomfort, 10 + extreme discomfort)**	
	On **AVERAGE** your complaint is	At **WORST** your complaint is
1.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Please Indicate Areas of Pain



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IMPORTANT: Complete these documents as thoroughly as possible, please be honest with yourself. Some of the questions that follow may seem unrelated to your condition, BUT they may play a major role in diagnosis and treatment. **All information is strictly confidential**.

Cancelation Policy

A **minimum of 24 hours' notice** is required if you need **to cancel or re-schedule** your appointment, otherwise a cancellation fee of a 100% applies.

Informed Consent Declaration

I declare that all the information disclosed on medical history and medications is correct and I give consent for treatment. If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I understand that methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, Gua Sha, Electrical stimulation, Remedial Massage, Sports Massage, Chinese Herbal Medicine services. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be of an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, dizziness or fainting, numbness or tingling near the needling sites that may last a few days. Burns and/or scarring are a potential risk of moxibustion, cupping and heat lamps. Bruising is a common side effect of cupping and Gua Sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax) or Infection, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant or experience any side effects immediately.

Patient Signature: _____Date: ____ /____ /_____

Patient Name: _____Date: ____ /____ /_____

Parent or Legal Guardian
(if under 18) printed name: _____Date: ____ /____ /_____

Parent or Legal Guardian

Signature: _____Date: ____ /____ /_____