Fort Saskatchewan ACUPUNCTURE

NEW PATIENT INTAKE FORM - MASSAGE Appointment Date: _____

Please complete the following pages so we can best meet your healthcare needs. If you have any questions, please do not hesitate to ask.

Personal Information

Name:

_____ _____ _____
(First) (Middle) (Last)

Date of Birth: _____
(DD/MM/YYYY)

Occupation: _____ **Relationship Status:** _____

Address: _____

City: _____ **Province:** _____ **Postal code:** _____

Phone numbers: _____ _____ _____
(Home) (Cell) (Other)

_____ _____
(Work) (Ext)

Main Email: _____
(Used for appointment reminders and other information, if any)

Emergency Contact Details:

Name: _____ **Relationship:** _____

Phone Number: _____

Physician Name: _____ **Physician Number:** _____

How were you referred to us? _____

Have you ever had a professional massage before? If so, when?

_____

What are your goals for this visit?

☐ Acupuncturist ☐ Chiropractor ☐ Physiotherapist
☐ Naturopath ☐ Osteopath ☐ Other: _____

Are you currently on any Medications? If so, please list and explain:

_____

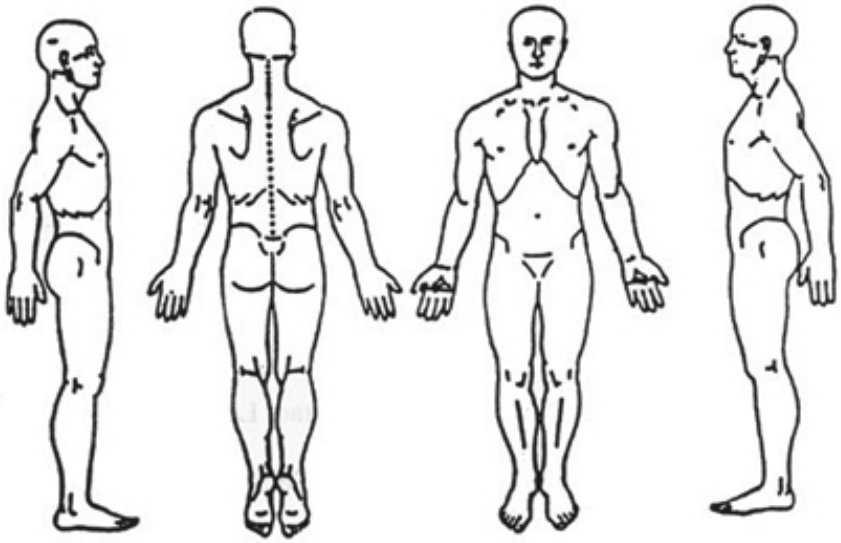
Please list any recent illnesses, accidents, injuries or operations:

_____

Reason (s) for visit:

_____

Please circle areas of discomfort below:



Please check all that apply to you currently:

- ☐ Allergies: _____
- ☐ Aneurysm / Stroke
- ☐ Anxiety
- ☐ Arteriosclerosis/Atherosclerosis
- ☐ Asthma
- ☐ Arthritis: _____
- ☐ Artificial Implants / Pins / Plates: _____
- ☐ Asthma
- ☐ Bruise easily
- ☐ Cancer: _____
- ☐ Chronic Cough
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ Crohn's
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Fibromyalgia
- ☐ Headaches: _____
- ☐ Hepatitis ___
- ☐ Hearing Difficulties
- ☐ Heart Attack/Heart Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Low Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Nausea/Vomiting
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Psoriasis
- ☐ Other: _____

Please list any diseases/symptoms that you have experienced in the past:

_____

CONSENT FOR TREATMENT

I, _____, hereby request and CONSENT to treatment utilizing any combination of the following: massage therapy, cupping, guasha, physical therapy, exercise therapy, and joint mobilizations to be performed by practitioners at Fort Saskatchewan Acupuncture Ltd.

I authorize sharing of relevant health information between Fort Saskatchewan Acupuncture practitioners for the purpose of treatment coordination.

I have had the opportunity to discuss with office/clinic personnel the nature and purpose of therapies mentioned above. I understand that results are not guaranteed.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned modalities of treatment. I intend this consent form to cover the entire course of treatment for any and all conditions treated at Fort Saskatchewan Acupuncture.

_____ (Patient/Guardian Signature)

Signed this _____ day of _____, 20_____

Fort Saskatchewan Acupuncture

#301, 10101 86 Ave
Fort Saskatchewan, AB, T8L 0T6
(587) 285-8012
www.fortsaskacupuncture.com

PAYMENT AND APPOINTMENT POLICIES

Patients are responsible for all payments for treatments and supplements. For your convenience, direct billing for insurance coverage is provided. However, the patient is responsible for payment of all outstanding dues not covered by the insurance provider.

For your convenience, appointments may be booked online or by telephone. Cancellations of at least 24 hours prior to appointment time may also be done via our online booking system or by telephone. However, appointment cancellations without 24-hour notice will be charged a $45 cancellation fee.

I, _____, understand and agree to the payment and appointment policies of Fort Saskatchewan Acupuncture Ltd.

_____ (Patient/Guardian Signature)

Signed this _____ day of _____, 20_____

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