

**Client Informed Consent to Treatment**

**I have discussed with my Traditional Chinese Medical (TCM) Acupuncturist the specifics of my assessment and/or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to TCM Acupuncture and understand that I may withdraw my consent and halt my participation at any time.**

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping, moxibustion, gua sha, and Tui-na. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. **My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.**
3. I will inform my practitioner if I currently have or develop major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. **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, Hepatitis.**
5. I understand that there are no guarantees for the results for the results of my treatments. TCM Acupuncture does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
6. **I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.**
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.
8. **Please inform your TCM acupuncturist if any of the following apply to you:**
  - **You are prone to dizzy spells or fainting**
  - **You are pregnant**
  - **You have a bleeding disorder**
  - **You are taking anti-coagulants, analgesics or any other medication**
  - **There are any areas of your body that you are not comfortable being treated directly**

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Practitioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent to Collect and Release Information**

I, \_\_\_\_\_, or my appointed representative \_\_\_\_\_

Consent

Do not consent

For Sara Hodgkinson, R.Ac. to collect and release my general client or medical information to other medical practitioners or health care providers/ support workers, emergency personnel and/or any other relevant organization.

In terms of information, Sara Hodgkinson, R.Ac. may collect any of the following:

- Contact information
- Personal or family medical history
- Medical Insurance or billing/ account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

**How Your Information Will be Used**

Your personal information may be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3<sup>rd</sup> party insurance companies with insurance claims
- To seek advice for potential treatment options
- To prevent or assist clients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

**Client Access to Information**

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

**Acknowledgment**

I allow for medical personnel to use and disclose my information as outlined above.

I understand that I can access my personal health information except as outlined above.

I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive.

My personal information can still be used/ disclosed if mandated by law.

**Client Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witnessed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Client Info & Medical History

Date of Initial Treatment (dd/mm/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Client Name</b> Surname:	Given Name(s):
Date of Birth: (dd/mm/yy): ____ / ____ / ____ Country of Birth:	Sex: _____ Identifies as: _____
Years in Canada:	

Contact Info			
Address:	City:	Province:	Postal Code:
Telephone: (c) _____ (h) _____ (w) _____	Occupation:		
Email:	Who can we thank for referring you?		
Physician: (Name)	(Phone)	(Address)	
Emergency Contact: (Name)	(Phone)	(Relationship)	

Health History			
Have you experienced any of the following? Please check all that apply. C=current P=previous			
Abscesses	<input type="checkbox"/> C <input type="checkbox"/> P	Epilepsy	<input type="checkbox"/> C <input type="checkbox"/> P
Acne	<input type="checkbox"/> C <input type="checkbox"/> P	Fatigue	<input type="checkbox"/> C <input type="checkbox"/> P
Alcoholism/Addiction	<input type="checkbox"/> C <input type="checkbox"/> P	Fibromyalgia	<input type="checkbox"/> C <input type="checkbox"/> P
Allergies	<input type="checkbox"/> C <input type="checkbox"/> P	Flu	<input type="checkbox"/> C <input type="checkbox"/> P
Anemia	<input type="checkbox"/> C <input type="checkbox"/> P	Gall Stones	<input type="checkbox"/> C <input type="checkbox"/> P
Anxiety	<input type="checkbox"/> C <input type="checkbox"/> P	Genital Herpes	<input type="checkbox"/> C <input type="checkbox"/> P
Arthritis (Type) _____	<input type="checkbox"/> C <input type="checkbox"/> P	Glaucoma	<input type="checkbox"/> C <input type="checkbox"/> P
Asthma	<input type="checkbox"/> C <input type="checkbox"/> P	Goiter	<input type="checkbox"/> C <input type="checkbox"/> P
Athlete's Foot	<input type="checkbox"/> C <input type="checkbox"/> P	Gout	<input type="checkbox"/> C <input type="checkbox"/> P
Back Pain	<input type="checkbox"/> C <input type="checkbox"/> P	Hay Fever	<input type="checkbox"/> C <input type="checkbox"/> P
Bell's Palsy	<input type="checkbox"/> C <input type="checkbox"/> P	Headaches	<input type="checkbox"/> C <input type="checkbox"/> P
Bleeding Disorder	<input type="checkbox"/> C <input type="checkbox"/> P	Heart Disease	<input type="checkbox"/> C <input type="checkbox"/> P
Bronchitis	<input type="checkbox"/> C <input type="checkbox"/> P	Hemorrhoids	<input type="checkbox"/> C <input type="checkbox"/> P
Cancer _____	<input type="checkbox"/> C <input type="checkbox"/> P	Hepatitis	<input type="checkbox"/> C <input type="checkbox"/> P
Canker Sores	<input type="checkbox"/> C <input type="checkbox"/> P	HIV	<input type="checkbox"/> C <input type="checkbox"/> P
Chronic Cough	<input type="checkbox"/> C <input type="checkbox"/> P	Hypertension	<input type="checkbox"/> C <input type="checkbox"/> P
Chronic Fatigue Syndrome	<input type="checkbox"/> C <input type="checkbox"/> P	Infertility	<input type="checkbox"/> C <input type="checkbox"/> P
Chicken Pox	<input type="checkbox"/> C <input type="checkbox"/> P	Insomnia	<input type="checkbox"/> C <input type="checkbox"/> P
Cold Sores	<input type="checkbox"/> C <input type="checkbox"/> P	Irritability	<input type="checkbox"/> C <input type="checkbox"/> P
Depression	<input type="checkbox"/> C <input type="checkbox"/> P	Jaundice	<input type="checkbox"/> C <input type="checkbox"/> P
Diabetes (Type) _____	<input type="checkbox"/> C <input type="checkbox"/> P	Joint Pain	<input type="checkbox"/> C <input type="checkbox"/> P
Digestive Problems	<input type="checkbox"/> C <input type="checkbox"/> P	Kidney Disease	<input type="checkbox"/> C <input type="checkbox"/> P
Ear Infections	<input type="checkbox"/> C <input type="checkbox"/> P	Kidney Stones	<input type="checkbox"/> C <input type="checkbox"/> P
Eating Disorders	<input type="checkbox"/> C <input type="checkbox"/> P	Liver Disease	<input type="checkbox"/> C <input type="checkbox"/> P
Eczema	<input type="checkbox"/> C <input type="checkbox"/> P	Low Blood Pressure	<input type="checkbox"/> C <input type="checkbox"/> P
Edema	<input type="checkbox"/> C <input type="checkbox"/> P	Lupus	<input type="checkbox"/> C <input type="checkbox"/> P
Endometriosis	<input type="checkbox"/> C <input type="checkbox"/> P	Migraines	<input type="checkbox"/> C <input type="checkbox"/> P
		Multiple Sclerosis	<input type="checkbox"/> C <input type="checkbox"/> P
		Nosebleeds	<input type="checkbox"/> C <input type="checkbox"/> P
		Ovarian Cysts	<input type="checkbox"/> C <input type="checkbox"/> P
		Palpitations	<input type="checkbox"/> C <input type="checkbox"/> P
		Parasites/Worms	<input type="checkbox"/> C <input type="checkbox"/> P
		Parkinson's	<input type="checkbox"/> C <input type="checkbox"/> P
		Pelvic Inflammatory Disease	<input type="checkbox"/> C <input type="checkbox"/> P
		Pleurisy	<input type="checkbox"/> C <input type="checkbox"/> P
		Polio	<input type="checkbox"/> C <input type="checkbox"/> P
		Pre-eclampsia	<input type="checkbox"/> C <input type="checkbox"/> P
		Prostate Disease	<input type="checkbox"/> C <input type="checkbox"/> P
		Psoriasis	<input type="checkbox"/> C <input type="checkbox"/> P
		Respiratory Disease	<input type="checkbox"/> C <input type="checkbox"/> P
		Rheumatic Fever	<input type="checkbox"/> C <input type="checkbox"/> P
		Rosacea	<input type="checkbox"/> C <input type="checkbox"/> P
		Scarlet Fever	<input type="checkbox"/> C <input type="checkbox"/> P
		Shingles	<input type="checkbox"/> C <input type="checkbox"/> P
		Styes	<input type="checkbox"/> C <input type="checkbox"/> P
		Strokes	<input type="checkbox"/> C <input type="checkbox"/> P
		Thyroid Problems	<input type="checkbox"/> C <input type="checkbox"/> P
		Tonsillitis	<input type="checkbox"/> C <input type="checkbox"/> P
		Tuberculosis	<input type="checkbox"/> C <input type="checkbox"/> P
		Uterine Fibroids	<input type="checkbox"/> C <input type="checkbox"/> P
		Urinary Tract Infections	<input type="checkbox"/> C <input type="checkbox"/> P
		Yeast Infections	<input type="checkbox"/> C <input type="checkbox"/> P
		Other:	<input type="checkbox"/> C <input type="checkbox"/> P

**Family Health History**

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**Women's Health:**

Start date of last menstrual cycle:	Age of first menses:	# of Pregnancies:	# of miscarriages / abortions:
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**Lifestyle** (Check any of the following that you currently use & indicate how long & frequently you use them.)

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Recreational Drugs
<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Pain relievers
What do you do for exercise? How often?	Are your energy levels low/average/high/fluctuating?	

**OFFICE USE: C/I and Red Flags:**

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