ESSENCE
WELLNESS CLINIC

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ACUPUNCTURE INTAKE

(also used for Cupping and Gua Sha)

Patient Information:

Name: _____ Date: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: (H) _____(Cell) _____
Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____
Occupation: _____ Email: _____
By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.
In case of emergency, who should we contact: _____
How did you find out about our services? _____

What are your main complaints?

_____
_____
_____

Details regarding Major Complaint:

Where is the problem located?_____
When did it start? How? _____
Have you had this condition before? When?_____
Is it getting worse? _____ coming and going?_____ getting better?_____
How often does it bother you? _____
Is there a pattern? Time of day _____ Time of year/season _____
What makes it better? Heat____ Cold____ Pressure____ Other_____
What makes it worse? Heat____ Cold _____ Pressure _____ Other _____
Describe the pain, if any: Dull/Aches ____ Shooting____ Other (pin prick, tight, squeezing, band sensation, expanding…) _____
Does the pain radiate anywhere?_____
Severity of pain out of 10 (10 = worst pain) _____

Please list all **allergies/sensitivities**:

_____

Please list any **medications** and **supplements** you are currently taking and **dosage**:

_____
_____

Please list all **accidents**, **surgeries** or **hospitalizations** and the **year** they occurred:

_____ _____
_____ _____
_____ _____

Consent for Treatment with Essence Wellness Clinic

I am hereby requesting Traditional Chinese Medicine treatments from Essence Wellness Clinic which includes Acupuncture and may or may not include Cupping and Gua Sha. I have discussed any complications and concerns with my practitioner. New complications and concerns, if they do arise, will be discussed with my practitioner, and appropriate action will be taken. I understand that although these are natural and alternative treatments I am seeking, there may be risks of bruising, pain in treated area, and worsening of symptoms during the healing process. I hereby release Essence Wellness and all practitioners/therapists treating me from all liabilities.

I am also aware of the clinic's late cancellation policy of a charge of **50% of the visit cost** if I fail to give **less than 24 hours notice for cancellations**. **I will be responsible to pay that charge before I can re-book.**

Signature _____ Date_____