ESSENCE
WELLNESS CLINIC

ACUPUNCTURE INTAKE

(also use this form for Cupping Intake)

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? To where?_____

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 other ancillary treatments such as cupping, gua sha, acupressure, ear seeds, heat lamps and TENS machines. 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, fainting, dizziness, 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_____