

## Elements Acupuncture and Wellness

### Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/ or substances from Traditional Chinese Medicine by the licensed Acupuncturist, Fynn Wu, R.Ac., of Elements Acupuncture and Wellness.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Cupping:** I understand that if I receive cupping as part of therapy, there is a likelihood of bruising and/or discoloration on the body-area on which cupping is performed. There may also be a slight probability of mild discomfort from this procedure. I understand that I may refuse this therapy.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction of diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to : changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Acupuncture & Wellness Center immediately.

**Acupressure/ Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of parent or guardian if patient is a minor (under 18 years of age)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Health History Questionnaire

Please complete this document as thoroughly as possible. 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*

### I. General Patient Information

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, Province, Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Major Complaint(s), in order of significance to you:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

How do these conditions interfere with your daily activities?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Please list any medications that you are taking:

\_\_\_\_\_

\_\_\_\_\_

Please list any surgeries you have had and when:

\_\_\_\_\_

\_\_\_\_\_

Please list any allergies you have:

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## II. Patient Medical History

How was your childhood health?

Recent tests- Please indicate test results and date below.

- Physical       Blood       Mammography       Pap Smear       Prostate  
 Cholesterol       HIV/STD       Other: \_\_\_\_\_

Test Results and Date: \_\_\_\_\_

Check any you have had in the past.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Gonorrhea         | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Mumps             | <input type="checkbox"/> Multiple Sclerosis     |
| <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Paralysis              |
| <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Syphilis          | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Measles           | <input type="checkbox"/> Migraines              |
| <input type="checkbox"/> CVA (Stroke)     | <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Vein Condition   | <input type="checkbox"/> Nervous Disorder  | <input type="checkbox"/> Other Lung Illnesses   |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Meningitis        | <input type="checkbox"/> Other Liver Illnesses  |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> HIV               | <input type="checkbox"/> Other Heart Illnesses  |
| <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Polio             | <input type="checkbox"/> Other Kidney Illnesses |
| <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Mononucleosis     | <input type="checkbox"/> Other                  |
| <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Epilepsy          | <input type="text"/>                            |
| <input type="checkbox"/> Jaundice         | <input type="checkbox"/> High Fever        | <input type="text"/>                            |

Immunizations: \_\_\_\_\_

Any Adverse Reactions? \_\_\_\_\_