Jessica Zerr
ACUPUNCTURE

Date

Last Name	First	Middle Initial
Birth Date	Occupation	
Phone: Cell	Home	
Address		
City	Postal Code	
Email		

Please note a minimum of 24 hours notice is required for any cancellations or changes.
The full appointment fee will be charged for all missed appointments or late cancellations.

Emergency Contact Name	Phone
Family Physician Name	

How did you hear about Your Practitioner/The Electra Health Floor?

☐Internet Search ☐Social Media ☐Live/work in neighbourhood

☐Referral (who do we have to thank for your referral?) _____

☐Other (please specify)

CONFIDENTIAL HEALTH INFORMATION

Is this visit related to an ICBC Claim? YES NO
(If YES, please skip PART I and ask reception for PART II)

History of Injuries and Surgeries (car accidents, broken bones, sports injuries):

Current Medications or Supplements:

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

Please list any sports, activities or hobbies you regularly participate in:

Number of times you exercise per week:____

PART I: CURRENT CONDITION

Describe your current condition(s):

When did it start?

How did it start?

Describe your symptoms: (Aching, stabbing, shooting, burning, numbness or tingling, etc.)

What activities/movements AGGRAVATE your symptoms (sports, hobbies, work etc.)?

What activities/movements RELIEVE your symptoms?

Is this condition getting progressively worse? YES NO CONSTANT INTERMITTENT

Have you seen a Physician or a Healthcare Practitioner regarding your current condition? YES NO Please list:

Have you had Imaging or X-rays taken related to this condition? Please list:

Have you had a similar problem in the past? When?

Other areas of pain or concern?

PART III: Please indicate if you **CURRENTLY** have any of the following

General
__Insomnia
__Rapid weight gain
__Rapid weight loss

Head
__Blacking out
__Dizziness
__Fainting
__Head Trauma
__Headache

Eyes
__Cataracts
__Flashes in vision
__Glaucoma
__Light sensitivity
__Spots in vision

Ears
__Discharge
__Dizziness
__Earache
__Impaired Hearing
__Ringing/ tinnitus

Mouth and Throat
__Bleeding gums
__Cold sores
__Goiter
__Hoarseness
__Jaw/TMJ problems
__Sore throat
__Swollen glands

Nose
__Loss of smell
__Nosebleeds
__Sinus problems

Lungs
__Asthma
__Bronchitis
__Coughing blood
__Coughing phlegm
__Difficulty breathing
__Emphysema
__Infections
__Persistent cough
__Pneumonia
__Shortness of breath
__Tuberculosis

Vascular
__Ankle swelling
__Calf pain
__Chest pain
__Cold feet/hands
__DVT
__Heart disease
__High blood pressure
__Leg cramps
__Low blood pressure
__Murmurs
__Pacemaker
__Palpitations
__Varicose veins

Gastrointestinal
__Abdominal pain
__Bloating/gas
__Blood in stool
__Constipation
__Diarrhea
__Gallbladder disease
__Heartburn
__Hemorrhoids
__Hernias
__Liver disease
__Ulcers
__Vomiting/nausea

Urinary
__Blood in urine
__Difficulty urinating
__Frequent infections
__Frequent urination
__Incontinence
__Kidney stones
__Pain urinating
__Urinary urgency

Neurological
__Aneurysm
__Difficulty walking
__Loss of memory
__Muscle weakness
__Numbness
__Paralysis
__Poor coordination
__Seizures/epilepsy
__Speech problems
__Strokes
__Tingling sensation

Muscle & Bone
__Arthritis OA/RA
__Bone pain
__Dislocations
__Fractures
__Joint pain
__Rods/Screws/Plates
__Spinal Injury
__Swollen joints

Skin
__Changes in moles
__Eczema
__Itching/hives
__Psoriasis
__Rash

Endocrine
__Diabetes Type I /Type II
__Excessive sweating
__Excessive thirst
__Heat/cold intolerant
__Hormone therapy
__Hypoglycemia
__Night sweats
__Thyroid problems

Emotional
__Alcohol/drug abuse
__Anxiety/nervous
__Depression
__Mood swings
__Phobias

Conditions
__AIDS/HIV
__Anemia
__Cancer/tumor
__Chronic fatigue
__Eating disorders
__Fibromyalgia
__Gout
__Heart condition
__Hemophilia
__Hepatitis
__High cholesterol
__Migraines
__Multiple sclerosis
__Parkinson's
__Polio
__Rheumatic fever

Other
__Implants
__Transplants
Other:_____

For women only: Is there any chance you are pregnant? YES NO

PLEASE NOTE
Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you please provide us with **24 HOURS NOTICE OF CANCELLATION, OR A CANCELLATION FEE OF THE FULL COST OF THE TREATMENT WILL BE CHARGED.** Payment for all treatment, whether private or insured, is the responsibility of the patient.
I authorize the Electra Health Floor Inc. and its associated practitioner(s) to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated practitioners to communicate with my referring MD as deemed necessary for benefit of my treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature

Patient Informed Consent for Acupuncture & Traditional Chinese Medicine Treatment

Acupuncture treatments are used with the intention of stimulating the body to naturally heal itself. Acupuncture treatments involve several treatment modalities including, sterile single-use needles which are inserted into the skin, electro-acupuncture (electro-stimulation of acupoints), cupping (the use of suction cupping technique on the skin), moxibustion (the use of chinese herbs and heat applied to the skin), Tui Na (a form of traditional Chinese massage) and herbal formulas may be involved in the procedure, with or as a substitute to the acupuncture treatment. It is not our intent as Traditional Chinese Medicine (TCM) practitioners and Acupuncturists to diagnose any medical conditions, but rather provide a thorough assessment from a TCM perspective.
Potential risks of Acupuncture & TCM include but are not limited to:

- Fainting and dizziness
- Bleeding, bruising and/or swelling
- Temporary exacerbation of symptoms
- Change in sensation
- Infection
- Puncture of internal organs, including Pneumothorax of the lung
- Allergic reaction to herbs
- Burns from moxibustion or TDP lamp
- Pregnant women: fetal distress or abortion

I _____(print name) hereby consent to my practitioner **Jessica Zerr RAc**, to provide treatment for me using Acupuncture & Traditional Chinese Medicine. I have read, been informed and understand the associated benefits and risks. I understand that I can withdraw my consent at anytime.

Patient Signature_____ **Date** _____

Parent/Legal Guardian Signature_____ Date:_____
(under 19 years old)
Witness Signature_____ Date:_____