Patient Informed Consent for Treatment

I, the person listed below*, have discussed with my acupuncturist/pharmacist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Traditional Chinese Medicine (TCM)/acupuncture and/or medication advice/review, and understand I may withdraw my consent and stop my participation at any time.

1. My practitioner, Angela Berscheid is a registered acupuncturist with the CTCMA. I understand that some of the techniques used under the scope of TCM include the use of sterile, single-use needles to penetrate the skin. Additional treatments can include, but are not limited to: acupuncture, acupressure, electrical stimulation of needles, cupping, moxibustion, gua sha, Qi Gong, and Tui Na. Before any of these procedures are performed, Angela will discuss my treatment options and will only proceed if my consent is given.
2. Angela has informed me of the risks and symptoms of treatments, which can include, but not are limited to: slight pain, light-headedness or nausea, soreness, slight bleeding or bruising of the skin, and the possibility of other very rare unforeseen risks. I freely accept the risks involved with my procedure.
3. If I require TCM herbs, Angela will consult a registered TCM herbalist or Dr TCM & will keep my case confidential.
4. I will inform Angela if I currently have or develop any major health issues, if I suffer from bleeding disorders, am taking blood thinners, wear a pace-maker or defibrillator, have diabetes, if I smoke or have a history of smoking (cigarettes/marijuana), have cancer or a history of cancer, am immuno-compromised, or am carrying HIV, TB, hepatitis & other infectious agents especially if cross-infection if high. In the latter case, Angela may withhold treatment.
5. I will inform Angela if I am, am planning to, or become pregnant.
6. I understand there are no guarantees for results of treatments. TCM does not often provide an instant cure. The length of my treatment depends on the severity of my condition, and how long I have had it. Sometimes my symptoms may temporarily worsen before they improve.
7. I allow Angela, registered pharmacist, access to my Pharmanet/Pharmacy profile in order for her to do a medication review. She may suggest herbs, supplements, & vitamins; any changes to prescriptions will be discussed with my family doctor.
8. I am responsible for the full and prompt payment after services have been rendered. I am responsible for notifying Angela if I will be late or cancel. 24 hours notice is required otherwise an **$80 no show fee will be charged.**
9. I give consent for Angela to professionally communicate any health concerns with my family doctor. All information given to Angela will be kept confidential unless with your consent I authorize release of information to other healthcare providers. Legal parent(s)/guardian(s) (if I am under the age of 19 years) and designated Power of Attorney have access to my record.
10. I have discussed the content of this form with Angela. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my conformed consent for TCM treatments and pharmacy consultation.

*Patient Signature:_____Witnessed:_____

on this _____day of _____, 20____.

*Please circle if applicable: I am the Parent/Legal guardian *or* I have Power of Attorney of Patient

A. Patient Health Summary

Name:	Birthday:	Sex:
Address:	City:	PostalCode:
Phone: (h)	(c)	Email:
Occupation:		Marital Status:

Family/Emergency Contact Information

Name:	Relationship to Patient:
Phone: (h)	(c)
Name:	Relationship to Patient:
Phone: (h)	(c)

Family Doctor Information

Name:	Address:
	Phone #:

Also seen by: ☐ physiotherapist ☐ massage therapist ☐ chiropractor ☐ osteopath ☐acupuncturist ☐psychologist/counselor ☐other

How did you find out about us:

List up to 3 reasons why you need treatment in order of severity:

1.

2.

3.

History of Present Illness: to be filled out in clinic.

Risk Factors: ☐pregnant ☐trying to be pregnant ☐fear of needles ☐history of fainting ☐low blood sugar ☐diabetes ☐low blood pressure ☐high blood pressure ☐bleeding disorder/on blood thinners/ASA ☐pacemaker/defibrillator ☐arrythmias ☐hepatitis/HIV/TB ☐previous/current smoker (tobacco or marijuana) ☐epilepsy/convulsions ☐ low immune system/on prednisone or methotrexate ☐cancer ☐history of cancer

B. Patient Medical History (Ongoing problems, past illnesses, operations, accidents and their TREATMENT)

Childhood Diseases. Please circle: Recurring nose bleeds, frequent ear infections, tonsillitis, much dental work, asthma, pneumonia, mono, easily catch colds/flus, chicken pox, frequent upset stomach, slow development, ADHD, ADD, autism spectrum, other:

PAST ADULT ILLNESSES, SURGERIES, TRAUMAS & THEIR TREATMENT:

Ongoing Health Conditions & their Long term Treatment:

Family Health Status (siblings, parents):

☐TB, asthma, emphysema ☐heart disease, high blood pressure, stroke ☐high cholesterol ☐diabetes ☐cancer ☐dementia ☐mental/emotional_____ ☐drug/alcohol abuse ☐liver disease ☐Epilepsy ☐Parkinson's Disease ☐Migraines ☐rheumatoid arthritis ☐premature aging/gray hair ☐allergies ☐other:_____

How many siblings do you have _____ and are you the ☐oldest, ☐in the middle ☐ youngest

Personal Allergies & Drug Reactions

☐Drugs:_____

☐Dust ☐perfumes/scents ☐environmental toxins ☐pollen/grass ☐latex(rubber) ☐peanuts/nuts ☐ Dairy ☐wheat ☐gluten ☐caffeine ☐chocolate ☐other

Please note if these are allergies or intolerances:

Medications/Supplements/Vitamins/Herbs/OTC's

Name:	Dose:	When started: Working? Y/N

Typical Diet and Exercise Program

Height: Weight: Favourite taste ☐bitter ☐sweet ☐spicy(savoury) ☐salty ☐sour

☐I comfort eat ☐I don't eat when stressed ☐coffee/black tea/cola_____cups/day ☐cigarettes _____cigs/day. Date when quit_____

☐marijuana ____doses/day ☐alcohol____glasses/bottles/ounces per day/week/mo or social

☐recreational drugs

Personal/Occupational Stress _____/10 (1 being minimal, 10 being extreme)

What helps?

What gives you joy?

Emotion Present most often: ☐relaxed ☐sad or depressed ☐frustrated or angry

☐tensed/keyed up/anxious ☐fright, panic ☐OCD ☐feel cut off from others ☐joyful ☐other

Date of last update						