



Traditional Chinese Medicine New Patient Intake Form

Date: ____/____/____

Personal Information

Name _____ Number of children _____ Ages _____
 Address _____ Marital status _____
 Suburb _____ Occupation _____
 State _____ Postcode _____ Referred by _____
 Home phone _____ Physician name _____
 Work phone _____ Physician's phone _____
 Mobile _____ May I contact? Yes No
 Email _____ Emergency contact name _____
 Birth date _____ Age _____ Relationship _____ Phone _____

Main Concerns

Please list your main concerns and reasons for this appointment (symptoms, diagnosis, duration etc.)

1. _____

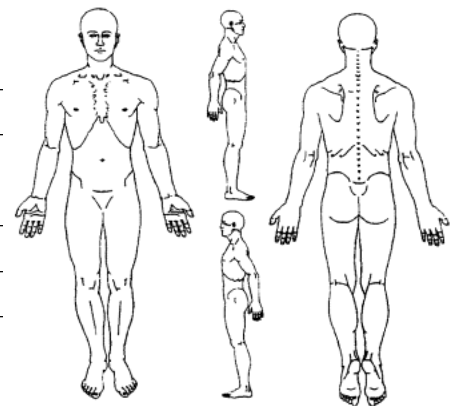
2. _____

3. _____

Have you seen any other doctors for this condition? If yes, please list doctor, prior interventions, and treatments _____

What makes your chief condition worse? (stress, fatigue, hunger, food, weather, etc.)

What makes your chief condition better? (rest, movement, heat, cold, eating, etc.)



Please mark areas of discomfort

Please mark the severity of your chief concern today.

No problem _____ Worst imaginable
 1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem _____ Worst imaginable
1 2 3 4 5 6 7 8 9 10

Please list all current Medications / Vitamins / Herbs

Name	Dosage	Duration	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal Medical History

Please mark all that apply and explain as necessary

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> HIV/AIDS _____ | <input type="checkbox"/> Other _____ |

Post Hospitalisations / Illnesses / Accidents (please list and date) _____

Please date and describe significant traumas (physical or emotional) _____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.) _____

Have you undergone a course of antibiotics lately? _____

Have you been under the care of a licensed health care professional in the past year? _____

If so, for what reasons? _____

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Drug/alcohol abuse _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mental disorder _____ | <input type="checkbox"/> Other _____ |

Review of Symptoms

GENERAL

- | | | | | | | | |
|---|--|---|---|---|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Past
<input type="checkbox"/> <input type="checkbox"/> Current | <input type="checkbox"/> <input type="checkbox"/> Frequent colds/infections
<input type="checkbox"/> <input type="checkbox"/> Chills
<input type="checkbox"/> <input type="checkbox"/> Fevers
<input type="checkbox"/> <input type="checkbox"/> Fatigue
<input type="checkbox"/> <input type="checkbox"/> Sudden energy drops
Time of day _____ | <input type="checkbox"/> <input type="checkbox"/> Past
<input type="checkbox"/> <input type="checkbox"/> Current | <input type="checkbox"/> <input type="checkbox"/> Night sweats
<input type="checkbox"/> <input type="checkbox"/> Poor sleeping
<input type="checkbox"/> <input type="checkbox"/> Localised weakness
<input type="checkbox"/> <input type="checkbox"/> Bleed/bruise easily
<input type="checkbox"/> <input type="checkbox"/> Sweats easily | <input type="checkbox"/> <input type="checkbox"/> Past
<input type="checkbox"/> <input type="checkbox"/> Current | <input type="checkbox"/> <input type="checkbox"/> Muscle weakness / fatigue
<input type="checkbox"/> <input type="checkbox"/> Poor balance
<input type="checkbox"/> <input type="checkbox"/> Tremors
<input type="checkbox"/> <input type="checkbox"/> Dental/gum problems
<input type="checkbox"/> <input type="checkbox"/> Strong thirst (hot/cold drink) | <input type="checkbox"/> <input type="checkbox"/> Past
<input type="checkbox"/> <input type="checkbox"/> Current | <input type="checkbox"/> <input type="checkbox"/> Poor appetite
<input type="checkbox"/> <input type="checkbox"/> Cravings
<input type="checkbox"/> <input type="checkbox"/> Sudden change in weight
<input type="checkbox"/> <input type="checkbox"/> Peculiar tastes/smell
Bitter/sweet/salty? |
|---|--|---|---|---|---|---|--|

SKIN AND HAIR

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Rashes
<input type="checkbox"/> <input type="checkbox"/> Eczema / Psoriasis
<input type="checkbox"/> <input type="checkbox"/> Skin discoloration
<input type="checkbox"/> <input type="checkbox"/> Dry skin | <input type="checkbox"/> <input type="checkbox"/> Ulceration
<input type="checkbox"/> <input type="checkbox"/> Acne
<input type="checkbox"/> <input type="checkbox"/> Face flushing
<input type="checkbox"/> <input type="checkbox"/> Changes in skin /hair | <input type="checkbox"/> <input type="checkbox"/> Hives/Allergic Dermatitis
<input type="checkbox"/> <input type="checkbox"/> Loss of hair
<input type="checkbox"/> <input type="checkbox"/> Dandruff
<input type="checkbox"/> <input type="checkbox"/> Itching | <input type="checkbox"/> <input type="checkbox"/> Recent moles
<input type="checkbox"/> <input type="checkbox"/> Warts
<input type="checkbox"/> <input type="checkbox"/> Weak or ridged nails
<input type="checkbox"/> <input type="checkbox"/> Fungal infection |
|--|--|--|---|

HEAD, EYES, EARS, NOSE AND THROAT

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Eye strain
<input type="checkbox"/> <input type="checkbox"/> Colour blindness
<input type="checkbox"/> <input type="checkbox"/> Eye pain / sore eyes
<input type="checkbox"/> <input type="checkbox"/> Dry eyes
<input type="checkbox"/> <input type="checkbox"/> Glasses/contacts
<input type="checkbox"/> <input type="checkbox"/> Excessive tearing
<input type="checkbox"/> <input type="checkbox"/> Poor or blurred vision | <input type="checkbox"/> <input type="checkbox"/> Poor night vision
<input type="checkbox"/> <input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> <input type="checkbox"/> Cataracts
<input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> <input type="checkbox"/> Recurrent sore throat/colds
<input type="checkbox"/> <input type="checkbox"/> Sores on lips/tongue
<input type="checkbox"/> <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> <input type="checkbox"/> Jaw clicks / locks
<input type="checkbox"/> <input type="checkbox"/> Earaches
<input type="checkbox"/> <input type="checkbox"/> Poor hearing
<input type="checkbox"/> <input type="checkbox"/> Ringing in ears
<input type="checkbox"/> <input type="checkbox"/> Nose bleeds
<input type="checkbox"/> <input type="checkbox"/> Sinus problems
<input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Facial pain
<input type="checkbox"/> <input type="checkbox"/> Headaches
Where _____
When _____
<input type="checkbox"/> <input type="checkbox"/> Migraines
Where _____
When _____ |
|---|--|---|---|

CARDIOVASCULAR

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Chest pain or pressure
<input type="checkbox"/> <input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> <input type="checkbox"/> Shortness of breath
<input type="checkbox"/> <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> <input type="checkbox"/> Low blood pressure
<input type="checkbox"/> <input type="checkbox"/> High blood pressure
<input type="checkbox"/> <input type="checkbox"/> Edema / swollen ankles
<input type="checkbox"/> <input type="checkbox"/> Varicose / Spider Veins | <input type="checkbox"/> <input type="checkbox"/> Cold hands / feet
<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Blood clots
<input type="checkbox"/> <input type="checkbox"/> Puffy eyes | <input type="checkbox"/> <input type="checkbox"/> Fainting spells
<input type="checkbox"/> <input type="checkbox"/> Dizziness / vertigo
<input type="checkbox"/> <input type="checkbox"/> Other _____ |
|---|--|--|---|

RESPIRATORY

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Cough / Wheezing
<input type="checkbox"/> <input type="checkbox"/> Coughing blood
<input type="checkbox"/> <input type="checkbox"/> Difficulty inhaling
<input type="checkbox"/> <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> <input type="checkbox"/> Tight sensation in chest
<input type="checkbox"/> <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Production of phlegm
Colour _____ | <input type="checkbox"/> <input type="checkbox"/> Bronchitis
<input type="checkbox"/> <input type="checkbox"/> Pneumonia
<input type="checkbox"/> <input type="checkbox"/> Other _____ |
|--|---|--|--|

GASTROINTESTINAL

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Nausea
<input type="checkbox"/> <input type="checkbox"/> Vomiting
<input type="checkbox"/> <input type="checkbox"/> Belching
<input type="checkbox"/> <input type="checkbox"/> Gas / flatulence
<input type="checkbox"/> <input type="checkbox"/> Indigestion
<input type="checkbox"/> <input type="checkbox"/> Bloating
<input type="checkbox"/> <input type="checkbox"/> Acid reflux / GERD
<input type="checkbox"/> <input type="checkbox"/> Bad breath | <input type="checkbox"/> <input type="checkbox"/> Excessive appetite
<input type="checkbox"/> <input type="checkbox"/> Changes in appetite
<input type="checkbox"/> <input type="checkbox"/> Hunger but no desire to eat
<input type="checkbox"/> <input type="checkbox"/> Chronic laxative use
<input type="checkbox"/> <input type="checkbox"/> Anorexia nervosa
<input type="checkbox"/> <input type="checkbox"/> Bulimia | <input type="checkbox"/> <input type="checkbox"/> Diarrhea
<input type="checkbox"/> <input type="checkbox"/> Black stools
<input type="checkbox"/> <input type="checkbox"/> Loose stools
<input type="checkbox"/> <input type="checkbox"/> Constipation (< 1 b.m./day)
<input type="checkbox"/> <input type="checkbox"/> and dry stools
<input type="checkbox"/> <input type="checkbox"/> not daily
<input type="checkbox"/> <input type="checkbox"/> with difficulty | <input type="checkbox"/> <input type="checkbox"/> Alternating constipation and diarrhea
<input type="checkbox"/> <input type="checkbox"/> Blood in stool
<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> <input type="checkbox"/> Hernia
<input type="checkbox"/> <input type="checkbox"/> Rectal pain/prolapse
<input type="checkbox"/> <input type="checkbox"/> Abdominal pain
<input type="checkbox"/> <input type="checkbox"/> Other _____ |
|---|---|---|---|

GENITO-URINARY

- | | | |
|--------------------------|--------------------------|---------------------------|
| Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain on urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Unable to hold urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Scanty flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Copious flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Dribbling after urination |

- | | | |
|--------------------------|--------------------------|-------------------------|
| Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Tract Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Night urination |
| | | How often? _____ |

MALE REPRODUCTIVE

- | | | |
|--------------------------|--------------------------|--------------------------|
| Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | Impotence |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature ejaculation |
| <input type="checkbox"/> | <input type="checkbox"/> | Nocturnal emission |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in testicles |
| <input type="checkbox"/> | <input type="checkbox"/> | Low sperm count/motility |
| <input type="checkbox"/> | <input type="checkbox"/> | Erection difficulty |

- | | | |
|--------------------------|--------------------------|-------------------|
| Past | Current | |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores on genitals |
| <input type="checkbox"/> | <input type="checkbox"/> | Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive libido |

FEMALE REPRODUCTIVE / GYNECOLOGICAL

- | | | |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Premenstrual irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular menses |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful menses |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy/prolonged bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Missed menses |
| <input type="checkbox"/> | <input type="checkbox"/> | Spotting/abnormal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Clots in menstrual blood |
| | | Color of blood _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult / painful intercourse |

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ovarian cysts |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Polycystic Ovarian Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast swelling or redness |
| <input type="checkbox"/> | <input type="checkbox"/> | Nipple discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap smear |
| <input type="checkbox"/> | <input type="checkbox"/> | Infertility |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| | | Do you practice birth control? |
| | | _____ |
| | | If so, list type and for how long? |
| | | _____ |
| | | _____ |

- Age of first menses _____
Duration of menses _____
First day of last menses _____
Number of days in cycle _____
- Are you pregnant now? _____
Is it possible you're pregnant now? _____
Are you trying to get pregnant? _____
Number of pregnancies _____
Number of Ectopic pregnancies _____
Number of live births _____
Number of premature births _____
Number of abortions _____
Age of menopause _____
Date of last PAP _____

NERVOUS SYSTEM

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis or seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance |

- | | | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Vertigo / Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste/smell/touch |

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling sensations/numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors |
| | | Where? _____ |

- | | | |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Concussion |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

MUSCULOSKELETAL

- | | | |
|--------------------------|--------------------------|---------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain |
| | | Where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain |

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand / wrist pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot / ankle pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint / bone problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sprains / strains |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain/weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Sciatica |
| <input type="checkbox"/> | <input type="checkbox"/> | Herniated disc |

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Carpal tunnel |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower body weak/aches |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

EMOTIONAL

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Often stressed |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily angered |
| <input type="checkbox"/> | <input type="checkbox"/> | Aggressive behaviour |

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty concentrating |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Over thinking |

- | | | |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Manic-Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | ADD / ADHD |

- | | | |
|--------------------------|--------------------------|---------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Panic attacks |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

SLEEP

- | | | |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty falling asleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake up easily during the night |
| | | Times per night? _____ |
| | | At a particular time? _____ |

- | | | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Wake up too early in the am |
| | | What time? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nightmares |
| <input type="checkbox"/> | <input type="checkbox"/> | Vivid dreams |

- | | | |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Grinding teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | Talking in sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring |

Lifestyle / Self Care

Do you allow time to relax? Yes No If yes, how? _____

Please rate the following areas:
great good ok poor bad
Family 5 4 3 2 1
Do you exercise regularly? Yes No Partner 5 4 3 2 1
Length of activity _____ Days per week _____ Libido 5 4 3 2 1
Types(s) of exercise _____ Self 5 4 3 2 1
How many hours per week do you work? _____ Work 5 4 3 2 1
What are the major stressors in your life? _____ Exercise 5 4 3 2 1
Spirituality ... 5 4 3 2 1

Do you use the following?

Tobacco frequently occasionally never Number of cigarettes per day ____ Age started _____
Alcohol frequently occasionally never Number of drinks per week ____ Type of drinks _____
Caffeine frequently occasionally never Number of cups per day ____ Type of drinks _____
Recreational drugs frequently occasionally never Number of times per month ____ Type of drug _____

Do you have any current or past problems with addiction or substance abuse? Yes No

Substance _____ Amount _____ When did you quit? _____

Please mark those that you use:

Pacemaker Contact Lenses Hearing Aid Artificial Limb
 Birth Control IUD Eyeglasses Dentures Brace (neck, arm, back)

DIET

Please list some of your favourite foods _____

How many meals do you eat per day? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? Yes No Do you frequently eat in between meals? Yes No

Do you eat when you are not hungry? Yes No Do you eat until you feel full? Yes No

How much liquid do you drink per day? _____ cups What types (water, soft drink, beer)? _____

Do you eat raw fruits and vegetables at least twice per day? Yes No Meat products? Yes No

Do you eat dairy products? Yes No Soy products? Yes No

"Typical Breakfast" _____

Lunch _____

Dinner _____

Additional Comments

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What is acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. Single-use, sterile, disposable needles are used in the clinic.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

What are the possible side effects of acupuncture?

- drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive
- minor bleeding or bruising occurs after acupuncture in about 3% of treatments
- pain during treatment occurs in about 1% of treatments
- symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign
- fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy. Please always follow your practitioner's prescription.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- if you have ever experienced a fit, faint or funny turn
- if you have a pacemaker or any other electrical implants
- if you are pregnant
- if you have a bleeding disorder
- if you are taking anti-coagulants (blood thinners) or any other medication
- if you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Appointment Policy

Welcome to Darling St Health Centre. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy. Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you. Occasionally, there is a problem with patient's time and, with that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24-hour notice for cancelled or rescheduled appointments is necessary in order to avoid the cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Privacy Policy

The information received and collected about our clients/patients from their visit to Darling St Health Centre is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Darling St Health Centre, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional (also, Darling St Health Centre will not give, share, sell, or transfer any personal information to a third party unless required by law). The client/patient information will be stored both in digital and hard copy format on Darling St Health Centre premises. On occasion, Darling St Health Centre may use client/patient information to conduct clinical studies to help us improve upon services provided.

Print name in full (Print name of Representative if represented by another)

Signature (Signature of Representative if represented by another)

Date