Barefoot
Acupuncture
Peterborough

Please read through the following conditions.
Check the category on the left and circle any signs or symptoms that you have experienced in the past or present.

Category	Signs or symptoms
__General	Weight changes, fatigue, weakness, fever, chills, allergies, sweating
__Skin	Itchiness, Rashes, Changes in Warts or Moles, Bruising, Eruptions
__Head/Ears	Head injury, headaches, dizziness, light-headedness, hearing issues
__Eyes	Changes in vision, dryness, redness, itchiness, eye diseases,
__Nose, Mouth Throat,	Ulcers, tooth and/or jaw pain, bleeding gums, sore throat,
__Lungs	Shortness of breath, difficulty breathing, asthma, cough, wheezing
__Heart	high/low blood pressure, palpitations, chest pain, arythmia, cold hands or feet, areas of numbness,
__Stomach	Indigestion, Gas, acid reflux, bloating, cramping, diarrhea, constipation, changes in bowel patterns, nausea, vomiting, loss of appetite, food sensitivities or allergies, IBS: painful bowel
__Urinary	Frequent urination, incontinence, nighttime urination, UTI infection
__Reproductive	Menstrual irregularity, painful periods, cysts, fibroids, PMS, endometriosis, low libido, impotence, infertility, breast pain, genital itching or irritation, infections
__Hormone Balance	Easily feel stress, low blood sugar, diabetes, lymph swelling, goitre, Metabolism fast or slow, tremors, hair loss, sleep problems
__Muscle/Skeletal	Muscle pain, bone and/or joint pain, back pain, neck pain, swelling, restricted range of motion, weakness, atrophy, injuries
__Neurological	Seizures, loss of consciousness, tremors, memory problems, nerve damage or numbness, balance problems, speech difficulties
__Psychological	History of trauma, mood swings, depression, anxiety, mental illness

Please include any other health information or details for the above that you think might be relevant.

Confidential New Patient Information Form

Please complete the questions on these pages to the best of your ability. If you feel more comfortable verbally communicating some of this information to the practitioner, or would like assistance filling in the information, please let us know.

Legal Name:	Date of Birth:
Preferred name:	Sex:
Home address:	Best phone to reach you:
Alternate phone: Email*:	Occupation:
Primary physician name, address and phone #:	Other health care providers you are seeing? Yes No
Emergency contact name & phone number:	Relationship to you:
Have you ever had acupuncture before? Y / N When?	Current living situation?
Please list any medications that you are currently taking, for how long and what they are prescribed for.	Medications
Please list any natural remedies and/or herbs, supplements that you're taking.	
Are you pregnant? What stage?	Do you have children? Y/N number + ages _________
Have you been diagnosed with any illnesses? Please list current and/or past including serious injuries and surgery.	
Family history of illness: please list any illnesses that members of your family have been diagnosed with.	

Lifestyle: please check the following that apply.

__Smoking	__Alcohol	_Drugs	__Caffeine
# per day____	drinks per week ____	addiction? Y/N	cups per day ____

Do you get exercise? Describe type and frequency.

Do you have dietary preferences and/or limitations?

On a scale of 1 to 10, please rate your overall stress level. _____________

List any types of stress you are experiencing. (Eg. Work, relationship, emotional, life changes..)

How much water and/or liquids do you drink daily? _________________
Are you:_ Always Thirsty _ Never Thirsty _ Thirsty but have no desire to drink

You prefer _ Hot Drinks _ Cold Drinks _ Drinks that are room temperature

Please rate your overall energy level on a scale of 1 to 10. ____________________

Main issue that you're hoping acupuncture can help with:

How long has this been an issue?
What makes it better?

What makes it worse?

Does this issue interfere with your ability to work? Y / N
Does it interfere with your ability to rest? Y / N

How much is this issue affecting your quality of life? (circle below: zero= no effect at all; 10=huge effect)

If the issue is pain, please circle both the *minimum* and *maximum* levels of pain it has been causing lately.

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Thank you for taking the time to give us this information. It will remain confidential.

Tips for New Patients

Please have a snack before your treatment if you haven't eaten recently.

Please avoid strenuous activity following a treatment.

INFORMED CONSENT FOR ACUPUNCTURE

Acupuncture involves the insertion of special needles into particular points on the body. The purpose of this treatment is to prevent or reduce pain and to help your body function better. It is considered to be a very safe procedure when done by
properly trained personnel. Risks include: temporary soreness; bruising and/or slight bleeding; and temporary weakness,faintness, or drowsiness (caution is advised when driving after treatments). Though rare, some people experience temporary aggravation of symptoms existing prior to acupuncture treatment. The acupuncturist uses only single-use, sterile, disposable needles; this means there is almost no risk of infection. If there are areas that you do not want touched or exposed, please let us know and we will choose from other available points. The acupuncturist will discuss your treatment with you prior to beginning and any concerns or modifications can be addressed along with the option to refuse the treatment.

PLEASE NOTE: We do not provide primary care, nor Western (allopathic) medical care. Please see a medical doctor for those services, and for routine check-ups. If you are pregnant, have a bleeding disorder, pacemaker, high or low blood pressure, local infection, or have been prescribed anticoagulant medications, please let us know. These situations do not preclude acupuncture treatment but knowledge of them will help us better care for you.

By consenting to treatment, I acknowledge that:

- I have read, or had read to me, and I understand, the information on this consent form and have disclosed all medically relevant information requested and I will inform my acupuncturist of any changes as soon as I am aware of them;
- I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my acupuncturist and have had my questions and concerns addressed. I understand that I can request more information at any time;
- I will report to the acupuncturist any dizziness or light-headedness that occur during or after treatment;
- I understand that I have the right to refuse and/or discontinue any treatment at any time. I understand that this refusal may affect the expected results;

- I voluntarily consent to receiving acupuncture and this consent will operate for future treatments; and I realize that no guarantees have been given to me regarding cure or improvement of thecondition(s) for which I am seeking treatment.

Furthermore, I have seen and understand the clinic’s financial policies and privacy policies, and agree to them.

______________________________________ ________________________

Signature Today’s Date