HEALTH HISTORY FORM - ACUPUNCTURE

Surname:_____ First Name:_____ Date:_____

Address: _____City: _____ Postal Code:_____

Home Tel #:_____Cell #:_____ Work #:_____

DOB (dd/mm/yyyy):_____Age: _____Marital Status:_____

☐ Click here if you do not wish to be contacted by email.

Email Address: _____

Medical Doctor's Name and Tel #: _____

Is this a WSIB injury? _____ Is this the result of a motor vehicle accident?_____

What is your major complaint?_____

Please describe your symptoms: _____

What makes it worse?_____

What makes it better?_____

How bad is your pain on a scale of 1-10, with 10 being your worst pain ever? _____/10

Please list any medical conditions:_____

List of medications: _____

What treatments have you received for your symptoms?_____

Have you had x-rays within the last two years?_____If so, please bring your report or x-rays with you

Have you had acupuncture before? _____ If yes, when? _____ Why?_____

Describe the results you had: _____

Are you a smoker?_____ If yes, # of cigarettes/day:_____ Do you exercise?_____

# of days/week you exercise:_____ Females - Do you suffer from PMS or Dysmenorrhea? _____

Occupation: _____

Any family history of: Arthritis:_____ Cancer: _____ High Blood Pressure:_____

Heart Disease: _____ Stroke:_____ Diabetes: _____ Other: _____

Is there anything else the doctor should be aware of? _____

Dr. Derek Ginter
Ajax Chiropractic & Wellness
#20-314 Harwood Ave. S., Ajax, ON L1S 2J1
(905)426-9004

Informed Consent for Acupuncture

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture as necessary, including electro-acupuncture by Dr. Derek Ginter or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture, there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment, which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

DO NOT SIGN THIS FORM UNTIL YOU HAVE DISCUSSED RISKS WITH THE DOCTOR

PATIENT NAME:_____

SIGNATURE: _____

DATE: _____

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Consent to Collect and Release Information

Dr. Derek Ginter, D.C. R.Ac

I, _____(print name),

or my appointed representative, _____(print name)

- ☐ CONSENT
- ☐ DO NOT CONSENT

For Ajax Chiropractic & Wellness to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations. In terms of information, the Clinic may collect any of the following:

- Contact Information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will Be Used:

Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

Acknowledgement

I allow medical personnel to use and disclose my information as outlined above. I understand that I can access my personal health information except as outlined above. I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments or Restrictions:_____

_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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