**Jill Forse Traditional Chinese Medicine**
**Registered Acupuncturist of NS, BScK**
**Client Intake Form**

**All information provided is held in strict confidence between you and your Acupuncturist.**

Name: _____ Date: _____
Address: _____
Email: _____ Phone#:_____
Date of Birth (mm/dd/yyyy): _____ Sex: _____
Occupation: _____
Medical Doctor: _____ Phone#:_____
Emergency Contact Name: _____ Phone #: _____
Health Insurance Information (Provider/Policy/Member ID): _____
Primary Plan Member Information (Name/Date of Birth):_____
Would you like to be enrolled in Text Message reminders for your appointments? YES or NO
Cell Phone#: _____

**Chief Complaint**: _____
_____
History of present ailment: _____
_____
**Other Health Concerns**: _____
_____
Medications (past/present) & Supplements: _____
_____
Allergies: _____
_____

**Previous Medical History**:
Have you suffered from any of the following? If yes, please indicate when:
High/Low Blood Pressure: _____ Heart Disease: _____Cancer:_____
Bleeding Disorders: _____Contagious Disease: _____Diabetes:_____
Traumas (physical and/or emotional): _____
_____
Previous Illnesses (adult or child): _____
_____
Surgeries: _____
_____
Other: _____
_____

Do you smoke? _____ Are you pregnant? _____Have you ever fainted? _____
Do you have a pacemaker? _____ Have you ever had Acupuncture before? _____
Do you have occupation related stress? _____

Referred by: _____

**Client Consent Form**

I, _____ (please print name) acknowledge and agree I have consented to the use of, or receipt of the following Treatment, at the clinic of Jill Forse Traditional Chinese Medicine as delivered by Jill Forse, Registered Acupuncturist of Nova Scotia.

I understand that acupuncture treatments involve the insertion of sterile, disposable needles at one or several points in the body and methods of treatments include the following, depending on the acupuncturist's judgment:

- Acupuncture
- Electroacupunture
- Auricular (ear) seeds and/or needles
- TDP lamp (infrared heat)
- Moxibustion
- Cupping
- Tuina (acupressure massage)
- Herbal recommendations
- Dietary recommendations
- Qigong/Tai Chi (movement meditation)

The undersigned, a person desiring acupuncture treatments administered by Jill Forse, acknowledges the following:

1. I understand the administration of acupuncture, regardless of modality, could directly or indirectly result in minor adverse effects to my body, including but not restricted to, dizziness, nausea, or feeling faint.

2. I understand I may suffer from allergic reactions or other reactions to herbs and foods suggested to me by my Practitioner during the course of Treatment. I will disclose any allergies and sensitivities to my Practitioner to reduce the risk of such reactions or complications.

3. I understand that although my Practitioner will take precautions to avoid medical complications, I also acknowledge there is a risk of minor bleeding, bruising, burns, soreness, pain, skin irritation, joint infection, and pneumothorax and needle breakage. Should such complications arise during Treatment or as a result of Treatment, I will be responsible for seeking further medical attention and my Practitioner and the Clinic will not be held responsible, in any manner, for such complications.

4. I have informed my Practitioner of any and all: (i) prescription drugs, medication, other drugs and remedies I am currently taking; (ii) illnesses, conditions, sicknesses (medical or otherwise); and (iii) medical treatment or health care treatments I am currently receiving.

5. The Services I receive are not in place of or in substitution of the care from a medical doctor, surgeon or other health care provider.

6. For the safety of myself and my Practitioner, I will disclose to my Practitioner all relevant past and current medical history. If I am unsure as to whether something may be relevant, I will ask my Practitioner. I will advise my Practitioner if I am trying to conceive, planning on trying to conceive in the near future, or if I am pregnant. I will also notify my Practitioner if I have any of the following: (i) infectious disease, including but not limited to AIDS, HIV, Hepatitis, Tuberculosis, or any form of Sexually Transmitted Disease; (ii) cancer (iii) hemophilia (iv) high blood pressure; (v) diabetes. I will advise my Practitioner if I have a pacemaker.

7. I understand that even though some extended health plans cover acupuncture, in the event I do not have coverage, it is my responsibility, as the client, to pay for treatment after each visit, and then seek reimbursement from my insurance company, if available.

8. I understand every statement on this form and all my questions related to this form and about the Services have been answered to my satisfaction prior to completing this form.

9. I understand that in order to be served better, **48 hours' notice of cancellation** is necessary. In the event that I miss an appointment or that insufficient notice of cancellation is given, the fee for the appointment will be billed to me.

I have discussed each item above with my Practitioner and understand and agree with each statement above. This consent form applies to my initial and all subsequent treatments. If any portion of any statement listed becomes inaccurate or untrue, I will notify my Practitioner immediately.

If you have any questions or concerns, please feel free to discuss them as I want to make this visit as pleasant as possible.

By signing below, I am agreeing to all statements set out above.

Patient or Person Authorized to Sign for the Patient: _____
Date: _____