AI TCM & MASSAGE THERAPY CLINIC

愛康中醫診所
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Edmonton, AB. T5L 5B9
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Client Information Form

File No: _____

Family name (print) _____ Given name (print) _____

Male [ ] Female [ ] Date of Birth:_____ Occupation _____

Address _____ City _____ Postal code _____

Phone (home) _____ Phone (work) _____

Cellular phone _____ E-mail _____

Contact person in emergency _____ Phone _____

Do you take any medications? Yes [ ] No [ ] Please specify: _____

Do you have cravings? Salty food [ ] Sweet food [ ] Other (specify): _____

Addictions: Yes [ ] No [ ] Coffee [ ] Smoking [ ] Other (specify) _____

Do you have allergy? Yes [ ] No [ ] Please specify: _____

Insurance coverage:_____ **Direct:**[ ] **Self:** [ ]

Second Insurance: _____

How did you know about our clinic? _____

Primary concerns and complaints: _____

Please check, if any of these conditions are applicable:

Arthritis [ ] Asthma [ ] Anxiety [ ] Allergy [ ] Back Pains [ ] Cancer [ ] Cold/Flu [ ]
Constipation [ ] Diabetes [ ] Diarrhoea [ ] Depression [ ] Digestive problems [ ] Dizziness [ ] Easy Bleeding [ ]
Fibromyalgia [ ] Fatigue [ ] Fever [ ] Hyper/Hypothyroidism [ ] Hyper/Hypotension [ ] Heart disease [ ]
Headaches [ ] Hepatitis [ ] HIV [ ] Insomnia [ ] Joint pain [ ] Migraines [ ] Pregnant [ ]
Stroke [ ] Skin Problems [ ] Sweating [Tuberculosis [ ] Urination problems [ ]
Others:

Attention Ladies:

Regular cycle Yes [ ] No [ ] Number of pregnancies [ ] PMS [ ]
Regular period length Yes [ ] No [ ] Number of childbirth [ ] Menopause [ ]

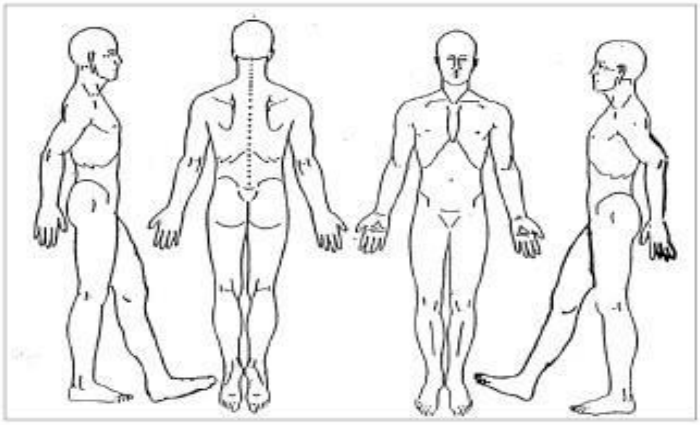
Attention Gentlemen:

Testicular pain [ ] Prostatitis [ ]
Premature ejaculation [ ] Urinary dysfunction [ ]

PTO…

Do you have pain at the present time? Yes [ ] No [ ]
Please circle the pain level: (low)-1-2-3-4-5-6-7-8-9-10-(high)

Please indicate the location of pain, numbness or paresthesia on the chart below:



Informed Consent Form

I hereby request and consent to the performance of one or more of the following therapies, such as acupuncture, herbal, massage, cupping or other procedures related to Complementary and Alternative Medicine (CAM) that are offered in this center. These procedures will be performed by registered therapists.

I have had the opportunity to discuss with the registered therapist the nature and purpose of each therapy or alternative care. I understand that results are not guaranteed. I further understand and I am informed that, as in all health care, in the practice of the therapies mentioned above, there may have more or less side effects. I do not expect the therapist to be able to anticipate and explain all risks and complications.

I wish to rely on the therapist to exercise judgment during the course of the procedures which the therapist feels at the time, based on facts then known, are in my best interest, and by signing below I agree on the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. All information provided will be held in strict confidence unless receiving a written request, along with a signed release form from the client. ALL or PART of client's records can be released to the client's personal representatives:
a) lawyer; b) insurance company; c) other health care professionals; d) others.

I agree that the therapist has the right to refuse, modify or terminate the treatment at any time if there is a reasonable cause. Need assessments treatments, procedures, likely benefits and risks of treatment have been and will be discussed between the therapist and me during the treatment.

A client has the right to refuse or terminate treatment at any time.

I acknowledge that I have read and understand this consent, and agree to its condition.

***Missed Appointment/No Show subject to a $50 service charge(24hr)**

Name of Client (Print)_____ Signature _____Date _____

Name of Guard (Print)_____Signature _____Date _____