Personal Information

Name: _____ **Today's Date:**_____ **Date of Birth:**_____

Phone number: _____ **Email address:** _____

Would you Prefer Email or Phone Reminders? Would you like to Receive Our Newsletter Yes/No?

Home Address: _____

_____

Emergency Contact : _____ **Relation:** _____

Phone number: _____

How did you hear about Harmony Family Wellness Centre?_____

Occupation : _____

Women Only:
Are you currently pregnant? **Yes / No** if Yes, how many weeks pregnant are you? _____
Are you trying to get pregnant? **Yes / No**
Past pregnancies? _____ Number of children: _____
Name of caregivers (Midwife, Doctor, Obstetrician) _____

Health Concerns

Please state the reason(s) for your visit today:

_____

_____

Please list any secondary concerns you may have about your health today:

_____

_____

Injuries and Hospitalizations: Please note any serious injuries and/or hospitalizations you have had.

_____

_____

Medications and Supplements: List any medications and/ or supplements you are currently taking. Include dosage.

_____ _____

_____ _____

Health History

Conditions: Please check conditions and symptoms you currently have or have had in the past:

□ Asthma	□ Lower back pain	□ Menstrual Disorders
□ Allergies	□ Chronic Pain	□ Low sex drive
□ Rapid weight loss	□ Arthritis	□ Urinary Tract Infection
□ Rapid weight gain	□ Pacemaker	□ Hernia
□ Respiratory difficulty	□ Bleeding Disorders	□ Poor memory
□ Migraines / Headaches	□ High Blood Pressure	□ Restlessness
□ Eczema	□ Palpitations	□ Insomnia
□ Fungal infection	□ Heart Disease	□ Psychiatric Care
□ Sweating (day / night)	□ Thyroid Disorder	□ Anxiety
□ Dizzy / vertigo	□ Kidney Disease	□ Depression
□ Ringing in the ears	□ Liver Disease	□ Bi Polar disorder
□ Ulcers	□ Cancer	□ Other: _____
□ Reoccurring colds/flus	□ Epilepsy	□ Other: _____

Energy level: (1-10): _____

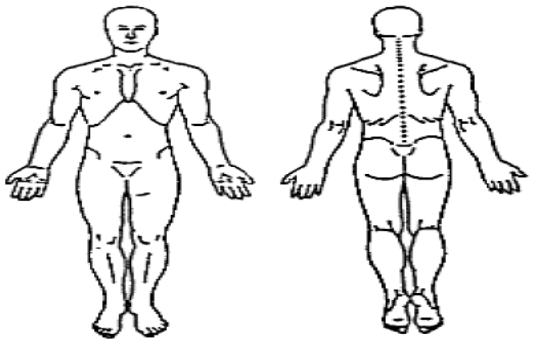
Please list any allergies to foods or drugs:

Appetite: (include any cravings and/or any digestive complaints)

Do you Smoke? (please include Cannabis use).

Family Medical History:

On the following drawings, please indicate the areas you feel should be addressed:



Commitment Statement

As healthcare providers, the Acupuncture Team is committed to helping people optimize their health and well-being. Our goal is one of partnership, where both the practitioner and the patient play vital roles in the patient's treatment, accelerating the healing process. Chinese medicinal herbs, massage and other modalities are used when appropriate, as well as recommendations on lifestyle, diet and exercise.

Consent

Acupuncture is generally very safe. Some risks or negative side effects include, drowsiness, bruising, mild discomfort during needle insertion and dizziness. Although uncommon, should you experience any of the listed symptoms or if you have any questions or concerns, please let your acupuncturist or reception know.

I _____ am aware of both the benefits and risks of acupuncture and Chinese medicinal herbs. I understand that this treatment is not a substitution for my primary care by a medical physician. I herby give my informed consent to receive treatment.

Signature_____ **Date**_____

Harmony Family Wellness Centre operates with a 24 hour cancellation policy. Any cancellations or rescheduling received within 24 hours of the scheduled appointment will be charged 100% of the regular fee.