TCM Rehab Clinic
Acupuncture, Traditional Chinese Medicine, Massage

511-4430 Bathurst Street,
Toronto On M3H 3S3
Tel: 41-398-9525 Fax: 416-398-9526
info@tcmrehab.com www.tcmrehab.com

Patient Health History and Consent Form

Initial visit date: _____ how do you know about us _____

Personal Information: Insurance Company _____

Last name _____ First name _____ Gender _____

Date of birth _____ Marital status _____ Occupation _____

Home address _____ City _____ Post code _____

Home phone _____ Mobile _____ Email _____

Emergency contact _____ Relationship _____ phone _____

Family Dr. _____ Phone: _____ Add: _____

Health History:

Height ____ Weight ____ Previous acupuncture (Y/N?) _____On blood thinner? _____

Pregnant (Y/N?) _____ History of surgery _____

Check the conditions or diseases had or having if apply:

Cardiovascular:	**Digestive System:**	**Respiratory System:**	**Infection**
❒ High Blood Pressure	❒ Reflux	❒ Cough	❒ Hepatitis: A, B, C
❒ Low Blood Pressure	❒ Abdomen Cramping	❒ Cold	❒ HIV
❒ Heart Attack	❒ Bloating	❒ Nasal catarrh	❒ TB
❒ Angina	❒ Constipation	❒ Asthma	❒ Herpes
❒ Bradycardia	❒ Hemorrhoids	❒ Emphysema	❒ Syphilis
❒ Tachycardia	❒ Irritable Bowel	❒ Sore throat	❒
❒ Stroke	❒ Hemorrhoids	❒ Short of breath	
Skin Condition:	**Ear , Nose, Eye:**	**Nerve and Immune:**	**Reproductive:**
❒ Allergy	❒ Deaf	❒ Fatigue	❒ Irregular period
❒ Itchy	❒ Tinnitus	❒ Insomnia	❒ Dysmenorrhea
❒ Eczema	❒ Rhinitis	❒ Depression	❒ Infertility
❒ Psoriasis	❒ Sinusitis	❒ Anxiety	❒ Endometriosis
❒ Skin tag	❒ Myopia	❒ Dizziness	❒ Hysteromyoma
❒	❒ Vision Blur	❒	❒ Fibroids
	❒ Glaucoma		❒ Fallopian tube blockage
	❒ Dry eyes		
Body Pain:		**Degenerative Disease:**	
❒ Headache/Migraines	❒ Foot pain	❒ Diabetes	❒ Others
❒ Back pain	❒ Arm pain	❒ Osteoporosis	
❒ Neck and shoulder	❒ Tennis elbow	❒ High blood pressure	
❒ Lumbago	❒ Sciatic		
❒ Leg pain	❒ Rheumatoid Arthritis		
❒ Knee pain	❒ Nerve pain		

TCM Rehab Clinic
Acupuncture, Traditional Chinese Medicine, Massage

511-4430 Bathurst Street,
Toronto On M3H 3S3
Tel: 41-398-9525 Fax: 416-398-9526
info@tcmrehab.com www.tcmrehab.com

Patient Informed Consent to Treatment

I, _____ or the person listed below, have discussed with my Traditional Chinese Medicine Practitioner or Acupuncturist the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure, I voluntarily consent to Traditional Chinese Medicine / Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, Gua sha, and Tuina. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness of nausea, soreness, bruising, bleeding or discolouration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my practitioner may withhold treatment.
5. I understand that there are no guarantees for the results of my treatment. Traditional Chinese Medicine dose not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in fully by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

Patient Signature _____ Date _____

Practitioner Signature _____ Date _____