The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: ____Date of Birth(DD/MM/YY): ____________________

Address:____City:________________________Postal Code:_______________

E-mail:_______________________________________ Phone No.: (_____)______________ Mobile No.: (_____)______________

Occupation: ____ Marital Status: _________________________ Gender:

Family Physician: _________________________________Phone No.: (_____) _______________ Fax No.: (_____) ________________

Address: ____ City: _______________________ Postal Code: ______________

Referring Health Care Provider: Name:____ Phone No: __________________________

Emergency Contact Name: ____Emergency Contact Phone No.: (_____) ____________

Personal and Family Medical History							
Check those that apply:	**Yourself**	Mother	Father	Grandparents	Brother	Sister	Children
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer (note type)							
COPD / Emphysema							
Depression							
Diabetes (onset)							
Epilepsy							
Glaucoma							
Headaches / Migraines							
Hearing / Vision Loss							
Heart							
Hepatitis / HIV / TB							
High/Low Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Mental Illness							
Pneumonia							
Skin Conditions							
Stroke							
Thyroid disorder							
Ulcers							
Other:							
Other:							

Current medication/supplement/herb	Condition it treats

Surgery/Injury/Hospitalisation	Date

Are you currently receiving treatment from another health care professional? ☐Yes ☐ No	
Type of practitioner	Condition treated

Chief Complain: ____
____

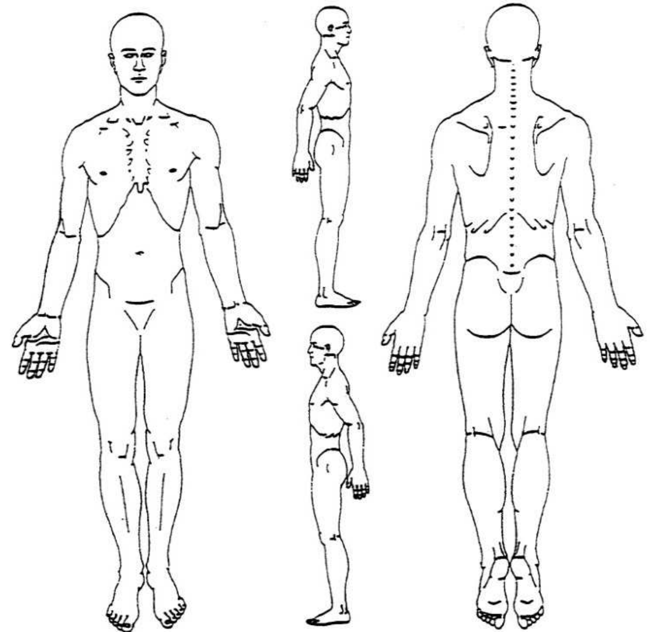
Onset: ____

Pain Level **0** (no pain) – **10** (highest possible pain): ____________

How would you describe the pain/discomfort: ☐ Dull ☐ Sharp

☐ Constant ☐ Radiating ☐ Other ______________________

Referring Professional's Diagnosis: ________________________
____



Please indicate areas of pain/discomfort using symbols:

/// TIGHTNESS	@ TENDER POINT	X PAIN
○○○ NUMBNESS	SWELLING	+++ TINGLING
--- WEAKNESS	___ OTHER:____________	

Late Arrival / Cancellation Policy/Payment Policy

I understand that I will be charged a fee (up to the full session fee) for any missed appointments or late cancellations, and that I am required to notify at least 24 hours in advance of my cancellation. I understand that late arrival reduces my treatment time and that a full session fee will apply when a late arrival does occur. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance.

Consent to Treatment

I hereby voluntary request to the performance of Acupuncture treatment on me by Registered Acupuncturist Sasa Marinkovic ("R.Ac").

It is my responsibility to disclose to the R.Ac all medical conditions affecting me and to keep the R.Ac updated on my medical history. I acknowledge and understand that the R.Ac must be fully aware of my existing medical conditions. I understand that I must let the R.Ac know if I am carrying, or believe to have any infectious agents, including but at not limited to HIV, TB and Hepatitis. In some cases where cross-infection is high, my R.Ac may withhold treatment.

I understand that there are no guarantees for the results of my treatments. Traditional Chinese Medicine does 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.

The R.Ac has provided me with information relevant to assessment, treatment, benefits and its methods and techniques, including but not limited to the use of acupuncture, laser acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, tuina, modalities, and manual techniques. I understand that some of the techniques include the use of sterile, single-use needles to penetrate the skin.

I have been explained and I understand the risks and side effects of the R.Ac techniques included but not limited to bruising, bleeding, discoloration of the skin, local pain/numbness/tingling, sprains, strains, light-headedness or nausea, and I have had an opportunity to ask questions. I understand that I can stop the assessment / treatment at any time.

I do not expect the R.Ac to be able to anticipate and explain all possible risks and complications and side effects of treatment, and I wish to rely on the R.Ac to exercise judgment during the course of treatment which the R.Ac thinks at the time, based upon the facts then known is in my best interest.

By voluntarily signing below I show that I have read, or have had read to me, and have fully understood this Consent and Late Arrival / Cancellation Policy / Payment Policy.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from R.Ac Sasa Marinkovic.

I acknowledge and declare that I am aware and fully agree to all of the above.

Client name: ____________________________________ Client signature: _____________________________

Date:_______________________

R.Ac Sasa Marinkovic use only: Date of Initial Health History:_______________

Update 1: _______________ Details of update:_____________________________________

Update 2: _______________ Details of update:_____________________________________

R. Ac Signature:________________________