

**WELCOME!**

Welcome to our clinic! We are delighted to have you as a new patient and we look forward to providing you with the highest quality of care.

**FEES**

Initial 60 minute treatment is **\$100** and subsequent Acupuncture treatments are **\$65-\$125**. Many extended health plans have an allowance for Acupuncture treatments; the amount varies depending on your plan. It is also possible to obtain coverage through MSP, CAF, VAC, and RCMP.

**SCHEDULING AND CANCELLATION POLICY**

We require a minimum of **12 hours** notice if you must cancel your appointment. If you miss an appointment, or fail to notify us in advance, a missed appointment fee will be applied.

I permit to communication with Energy Health Clinic via email for appointment reminders. You can unsubscribe at anytime.

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_ HEREBY CONSENT to Acupuncture treatment to be performed by Melissa Ridgway R.Ac., R.TCM.P.

**I understand that:** One time disposable needles are used in all treatments.

There may be a chance of bruising or slight soreness at some acupoints following treatment.

I will be consulted prior to the use of any acupoints that may be potentially dangerous or any treatment protocols that may cause any ill effects.

**I have read and understood the above consent for treatment**

Signature \_\_\_\_\_ Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address: \_\_\_\_\_

Phone(Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ Email: \_\_\_\_\_

Referred By: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

BC Care Card: \_\_\_\_\_ Have you tried Acupuncture before? YES/NO

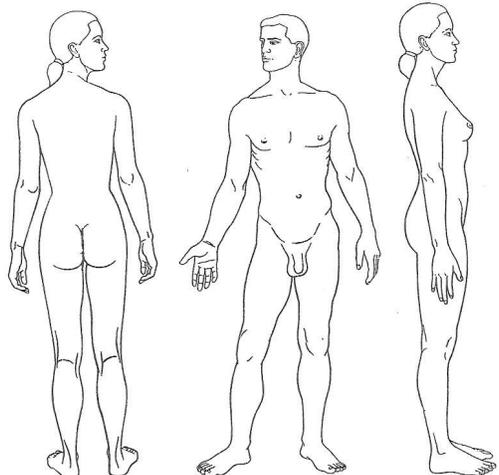
Private Health Care Plan/ID: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**MEDICAL HISTORY**

Please circle if any of the following apply to you:

- |                         |        |                            |        |
|-------------------------|--------|----------------------------|--------|
| Hemophiliac             | YES/NO | <b>Autoimmune disorder</b> | YES/NO |
| Pacemaker               | YES/NO | <b>Dizziness/Fainting</b>  | YES/NO |
| Epilepsy                | YES/NO | <b>Pregnant</b>            | YES/NO |
| Serious lung infection  | YES/NO | <b>Stroke</b>              | YES/NO |
| Diabetes                | YES/NO | <b>Arthritis</b>           | YES/NO |
| High/Low blood pressure | YES/NO | <b>Thyroid disorder</b>    | YES/NO |
| Cancer                  | YES/NO |                            |        |



**PAIN**

On the diagram above, please circle where you have pain in your body

**D = Dull**

How long have you had the pain? \_\_\_\_\_

**S = Sharp**

**T = Stabbing**

Aggravated by: \_\_\_\_\_

**H = Shooting**

**P = Pins & Needles**

Alleviated by: \_\_\_\_\_

**N = Numbness**

**B = Burning**

Have you tried other therapy for this condition? \_\_\_\_\_

**O = Other**

**PERSONAL HISTORY**

Medications and/or supplements you are currently taking: \_\_\_\_\_

Please list any allergies you may have: \_\_\_\_\_

Please list any blood-borne disease (HIV Hepatitis B etc): \_\_\_\_\_

Have you ever been Hospitalized and/or treated for any serious condition or surgery?

\_\_\_\_\_

Occupation: \_\_\_\_\_ Work: \_\_\_\_\_ Hours a week \_\_\_\_\_ Normal \_\_\_\_\_ Irregular \_\_\_\_\_ Shift work

Coffee: \_\_\_\_\_/Day Cigarettes: \_\_\_\_\_/Day Alcohol: \_\_\_\_\_/Day Drugs: \_\_\_\_\_/Day

Regular Exercise (type/frequency): \_\_\_\_\_

**SIGNS AND SYMPTOMS – Currently experiencing or have experienced within the past 3 months.**

**Muscle & Joints**

- Joint pain
- Body Heaviness
- Difficulty walking
- Numbness/tingling
- Spinal condition

**Nose, throat, mouth**

- Bleeding nose/gums
- Allergies/sinusitis
- Tongue/Mouth sores
- Dry mouth/thirst

**Ears**

- Hearing loss
- Tinnitus
- Ear pain

**Bowels**

- Loose stool/diarrhea
- Constipation
- Urgent bowels
- Bloating/gas
- Mucous/Blood/Black stool
- Hemorrhoids/fissure
- Intestinal cramping/pain
- itchy/burning anus

**Head & Neck**

- Dizziness/fainting
- Memory Loss
- Neck stiffness
- Headaches
- Migraines

**Respiratory**

- Chronic cough
- Cough up phlegm
- Cough up blood
- Shortness of breath
- Asthma wheezing
- Frequent colds

**Genito-urinary**

- Painful/burning urination
- Frequent urination
- Urgent/unable to hold
- Cloudy/bloody urine
- Pain/itching of genitals
- Genital discharge
- High/Low libido
- Kidney stone
- UTI's

**Eyes**

- Blurred vision
- Spots/visual changes
- Poor night vision
- Eye pain
- Red, burning, itchy, dry

**Appetite**

- Normal
- Poor
- Hungry
- Excessively hunger

**Cardio-Vascular**

- Heart Palpitations
- Rapid/Irregular
- Chest pain/tightness
- Poor Circulation
- Swelling of ankles

**Sleep**

- Hours of sleep at night
- Rested in morning
- Difficulty falling asleep
- Insomnia
- Dreams/nightmares
- Sound

**Menstruation**

- Regular
- Irregular
- cramps
- PMS
- Clots
- # of cycle days

**Skin**

- Hives/rash
- Eczema/psoriasis
- Acne
- Dryness
- Bruise/bleed easily
- Hair thinning/loss
- Nails break/flake off

**Digestive**

- Nausea
- Vomiting
- Heartburn/reflux
- Bad breath
- Gall bladder problems

**Emotions**

- Calm/relaxed
- Excessive joy/mania
- Sadness/grief
- High/easily stressed
- Angry/irritable
- Anxiety/over think/worry
- Difficult focusing

**General**

- Chronic/easily fatigue
- Excessive sweats
- Cold hands/feet/nose
- Always hot and/or cold
- Hot flash/Night sweats
- Dislikes cold/heat
- Recent weight changes
- Energy Level