ENERGY Chiropractic

Acupuncture – Initial Consultation Form

Personal Information

Date:______________

First Name: ____________________ Last Name: ____________________
Birth Date: ____________________ Gender: M ☐ F ☐
Home Address: ____________________________________ Postal Code:_______________
Home Phone: ______________ Business Phone: __________ Cell Phone:_______________
Occupation: _______________ Employer: ____________________
Emergency Contact: _________________ Phone: _________ Relationship:___________________
Provide email if we may contact you (appointment reminders) ___________________
How did you find out about our clinic? If recommended, please state name:__________________

Health Condition

Medical History

☐ Allergies	☐ Asthma	☐ Cancer
☐ HIV Positive	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Stroke	☐ Varicose Veins	☐ Phlebitis/Thrombosis
☐ Hepatitis	☐ Epilepsy/Seizures	☐ Heart Disease
☐ Diabetes	☐ Bleeding Disorder	☐ Thyroid Dysfunction

Other (please indicate):
____
____

Are you or is it possible that you are pregnant? Yes/No

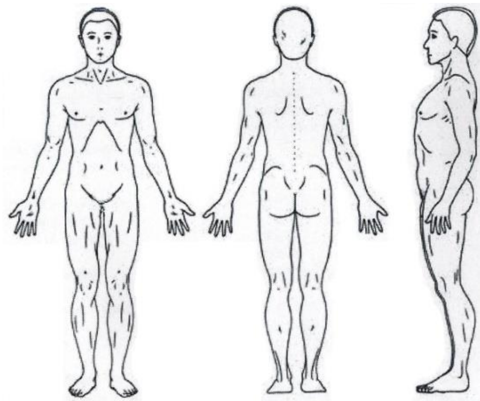
____

Are you currently wearing any electrical device or pacemaker?
If yes, please describe:
____

Are you currently taking any medication, herbal medications or supplements? Yes/No
If yes, please indicate name, dosage and how long you have been taking them:
____
____
____

Have you ever had any injury or surgery? Yes/No
If yes, please indicate the date, specific treatments received, and any relieving and aggravating factors:
____
____
____

Are you experiencing any pain or discomfort? Yes/No
If yes, please shade painful areas of injury, pain or discomfort on the figures below:
Rate painful areas 1-10   1=least painful 10= most painful



Is there anything else that we should be aware of your health condition?
____
____

Have you received any of the following alternative health services?

☐Acupuncture	☐Chinese Herbs	☐Therapeutic Massage
☐Physiotherapy	☐Chiropractic/ART	☐Other: ____________

Patient Name: _____________________ Patient Signature: ______________________

Date:_________________________

Insurance – Information Release (Optional)

I hereby confirm that Energy Chiropractic may release information concerning my treatment (dates, practitioner, fees paid) which may be requested by my Insurance Company**.**

Signature: ___________________________________ Date: ______________

Although our office does not direct bill third party insurance coverage, we do encourage our patients to check their benefit package regarding their coverage for the following services: chiropractic, acupuncture, massage therapy, orthotics. We will issue you receipts that you can submit for reimbursement.

Cancellation Policy

Cancelling or rescheduling appointments must be done 24 hours in advance. You may be charged for missed appointments.