

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

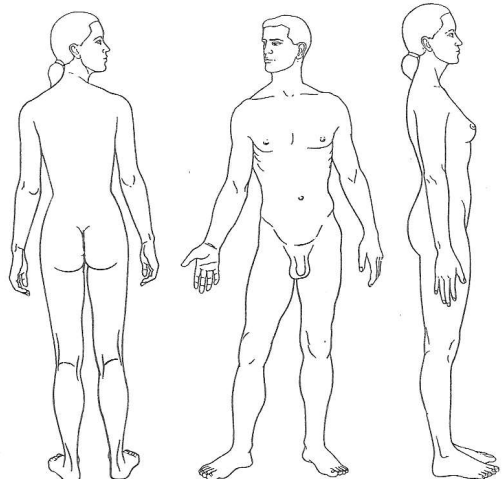
Private Health Care Plan/ID: _____

Reason for today's visit: _____

MEDICAL HISTORY

Please circle if any of the following apply to you:

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