NEWBALANCE
CHIROPRACTIC CLINIC

Acupuncture New Client Form

We would like to welcome you to New Balance Chiropractic Clinic, where it is our mission to provide you with the best holistic solutions for your individual needs. Before getting started, we believe it is crucial to get to know you and your situation intimately. Your health is our primary concern. If we believe our services are not the best solution for your individual needs, we will refer you to the appropriate health care provider.

Patient Identification

Name: _____ Gender: ☐ Male ☐ Female

Address:_____City:_____Prov:_____Postal Code:_____

Telephone: Home:_____Work:_____Cell:_____

Email:_____Date of Birth (m/d/y):_____Age: _____

Insurance Provider:_____Policy # / Member ID: _____

Occupation:_____Employer:_____

Emergency Contact:_____ Phone Number: _____

Alberta Health Care #:_____ Family Physician: _____

Date of last exam: _____

Referral Type: ☐Google ☐Facebook ☐Live/work in Area ☐Referral by:_____

Would you prefer appointment reminders via: ☐ home phone ☐ cell phone ☐ work phone ☐ email

Previous Chiropractic Care: ☐Yes ☐No Name of Chiropractor: _____

When:_____ Reason for visit:_____

Previous Massage Therapy: ☐Yes ☐No Name of Therapist:_____

When:_____ Reason for visit:_____

Patient Acceptance

Unless prior arrangements have been made, payment is due in full when services are rendered.
WCB and motor vehicle accident cases will be billed directly.

Cancellation Notice: Your appointment is an opportunity to address your health concerns. It is our goal to provide this opportunity in a timely manner to all members of the community. We respectfully ask that you provide at least 24 hours notice if cancellation is required. Please note that missed or cancelled appointments without appropriate notice will result in a charge of 50% of scheduled services being applied to your account.

I, the undersigned, understand and accept the statements above and that the practitioners of New Balance Chiropractic Clinic have the right to refuse or discontinue treatment at any time.

*Signature*_____ *Date* _____

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Patient History

Do you excercise?: ☐☐ Yes ☐☐ No How much? _____

Activities: _____

Do you smoke? ☐☐ Yes ☐☐ No How much? _____

How much water do you consume daily? _____

Do you consume alcohol? ☐☐ Yes ☐☐ No How much? _____

Have you ever been diagnosed with any of the following? Please check all that apply:

- ☐ Arthritis
- ☐ Epileptic Seizures
- ☐ Low/High Blood Pressure
- ☐ Neurological Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Cardiovascular Disease
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Musculoskeletal Disease

Have you ever or do you currently experience any of the following symptoms/conditions?
Please check all that apply:

- ☐ Asthma/Emphysema
- ☐ Chest Pain
- ☐ Migraine
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Difficulty Seeing
- ☐ Corrective Eyewear
- ☐ Easily Bruised
- ☐ Anxiety/Depression
- ☐ Skin Condition/Sensitivity
- ☐ Sexually Transmitted Disease/HIV
- ☐ Unexplained Weight Loss/Gain
- ☐ Sinus/Respiratory Infections
- ☐ Shortness of Breath
- ☐ Dizziness/Fainting
- ☐ Indigestion/Heartburn
- ☐ Hernia/Ulcer
- ☐ Eye/Ear/Nose Pain
- ☐ Difficulty Hearing
- ☐ Cardiac Pacemaker
- ☐ Allergy/Food Intolerance
- ☐ Anemia/Blood Clotting Disorder
- ☐ Fever
- ☐ Broken/Fracture/Dislocation

Females only: # of Pregnancies_____# of Children _____

Currently pregnant: ☐☐ Yes ☐☐ No

Have you ever experienced difficulties with your menstrual cycle (cramps, headaches, etc)? ☐☐ Yes☐☐ No

Please list all current **medications** and **supplements,** including dose and frequency:

Please list all **hospitalizations/surgeries**, including date and diagnosis:

Please list any previous **major traumas** (falls, motor vehicle accidents, sports injuries, etc):

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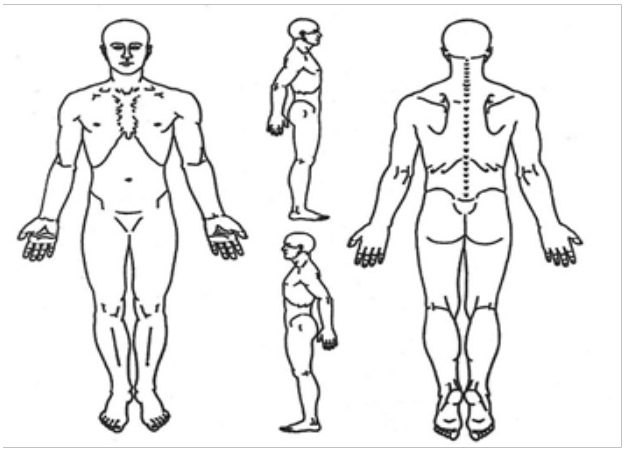
Current Complaint

Is your current complaint related to a work injury? ☐☐ Yes ☐☐ No

Is your current complaint related to a motor vehicle accident? ☐☐ Yes ☐☐ No

Please describe your primary symptoms:

Please indicate the location of your symptoms:



When did your symptoms first start? _____

How often do you experience symptoms?

☐☐ Minimally ☐☐ Weekly ☐☐ Every Other Day ☐☐ Daily ☐☐ All the Time

On a regular basis, how would you rate the intensity of your symptoms? Place an "X" on the scale below.

No pain ——————————————— Worst possible pain

Describe your symptoms:

☐ Stiffness ☐ Tingling ☐ Dull Ache
☐ Crampy ☐ Shooting ☐ Numbness
☐ Sharp/Stabbing ☐ Throbbing ☐ Other: _____

When are your symptoms the worst?

☐ Morning ☐ Mid-Day ☐ Night ☐ Other: _____

What aggravates your symptoms?

☐ Lifting ☐ Sitting ☐ Standing
☐ Inactivity/Rest ☐ Activity/Exercise ☐ Light/Noise
☐ Stress ☐ Fatigue ☐ Other: _____

What relieves your symptoms?

☐ Ice ☐ Heat ☐ Inactivity/Rest
☐ Activity/Exercise/Stretches ☐ Medication ☐ Other: _____

What are your goals for treatment?

☐ Relieve symptoms ☐ Overall wellness ☐ Increase functional abilities
☐ Reduce stress ☐ Improve range of motion ☐ Improve posture
☐ Improve range of health & wellness

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Acupuncture Informed Consent

Please read the entire consent carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including moxibustion, cupping, electro-acupuncture, Gua Sha, Chinese herbals and other techniques within the scope of practice of acupuncturists.

I further understand and am informed that in the practice of acupuncture, as in all healthcare, there are some slight risks to treatment; although all needles are pre-sterilized and disposable. These risks include, but are not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock.

I have read the above consent. I have also had an opportunity to ask questions about this content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name:_____ Witness Name:_____

Patient Signature:_____ Witness Signature:_____

Date (dd/mm/yy): _____

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