WELCOME TO OUR CLINIC!

Outline of Procedures for New Patients

Step 1: Confidential Patient Health Record
All new patients are requested to thoroughly complete the following pages.

Step 2: Consultation and Examination
You will receive a comprehensive consultation and examination to discuss your health concerns. This is to determine if acupuncture therapy is appropriate for your condition.

Step 3: Report of Findings
Following the examination, you will be informed of the results and a treatment plan can be discussed. As well, if indicated, appropriate referrals will be made to other allied health professionals for co-management of your condition.

Step 4: Treatment
Your treatment plan will commence and continue as scheduled until your condition has been fully corrected, or until maximum possible benefit has been obtained.

To save time and allow us to better serve you, please complete all questions to the best of your ability. Thank you!

Personal & Contact Information

❑ Check the box if we already have your current contact info. If so, please feel free to skip to the next section.

Name ____________________ Date of Birth mm/dd/yy ________ Sex ❑ M ❑ F

Address ____________________

City ____________ Province ____________ Postal Code ____________

Tel Home (____) ____________ Work (____) ____________ Cell (____) ____________

Email Address ____________________

*Why do I need your email? Email provides me a convenient method to communicate with you about your health and treatment.

Type of Work / Occupation ____________________

Emergency Contact (Name, Tel. & Relationship) ____________________

How did you hear about us? ____________________

Health History

Current Complaint(s) - in order of importance to you

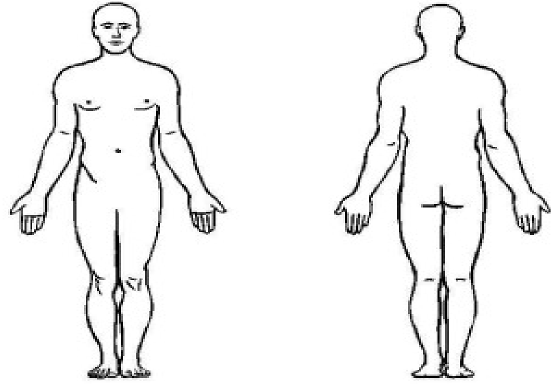
1.______________________________

2.______________________________

3.______________________________

How long/frequently have you had this/these issue(s)?

____



Please indicate areas of discomfort

For those who are suffering from a pain-related condition. Circle a number on the following scales (0 = no pain, 10 = worst pain)

Level of Pain Now	0	1	2	3	4	5	6	7	8	9	10
Level of Pain at its Worst	0	1	2	3	4	5	6	7	8	9	10

Have you sought medical attention for this complaint? ❑ Yes ❑ No

If Yes, please list previous treatments for this complaint: ______________________________

____

Has it been diagnosed medically? ______________________________

List any medications or supplements that you are currently taking ______________________________

____

Are you currently experiencing any ongoing medical conditions? ______________________________

____

Have you now or in the past, experienced any of the following issues or symptoms?

❑ Acute Pain	❑ Severe Infection	❑ Emotional Disorders	❑ Gastrointestinal Issues
❑ Chronic Pain	❑ Heart Conditions	❑ Sleep Disturbances	❑ Eyes/Nose/Throat
❑ Gynecological Issues	❑ Respiratory Conditions	❑ Skin Conditions	❑ Cancer/Tumours

Please provide additional info for those issues checked above: ______________________________

____

____

Have you had acupuncture therapy before? ❑ Yes ❑ No

Was it for the same condition? ❑ Yes ❑ No

Are you currently pregnant or suspect that you may be pregnant? ❑ Yes ❑ No

Patient's Consent

We value the trust you have placed in us and are taking all appropriate measures to safeguard your personal information and confidence. We have established a privacy policy to ensure that your personal information and personal health information is protected. Our privacy policy is available at our reception and at www.satoriwellness.com. In accordance with our privacy policy, we request that you provide your consent as set out below.

Consent to acupuncture therapy

I acknowledge and understand that an acupuncture treatment involves the penetration of skin by sterile single-use disposable filiform needles. Additional methods of treatment such as electroacupuncture stimulation, acupressure, heat lamp, cupping (application of suction to acupuncture points), or medicated lotion may be used during treatment. I understand that I may experience temporary light-headedness, drowsiness, soreness or bruising and the possibility of other unforseen risks following an acupuncture treatment. I freely accept these risks involved with the procedure.

I will inform the practitioner if I currently have or develop any major health issues, such as a bleeding disorder, using a pacemaker, or afflicted with an infectious disease (including but not limited to HIV, hepatitis B and TB). I agree to inform the practitioner if I am currently pregnant, suspect that I am pregnant or actively trying to become pregnant. I agree to inform the clinic if there are any significant changes to the state of my health during the course of treatments.

I hereby give my consent for a consultation and treatment. I am also aware that Satori Health & Wellness will bear no responsibility in the event of any injury or harm that may occur as a result of treatment reasonably and professionally administered.

Consent to collect, use and disclose patient information

I agree that Brendan Cheung R.TCMP/R.Ac and Satori Health & Wellness can collect, use and disclose my personal information and personal health information provided by me in this health inquiry form to provide me with the services I request and for other limited purposes set out in the Satori Health and Wellness' privacy policy.

By my signature below, I ______________________________ (Patient) hereby agree that Brendan Cheung R.TCMP/R.Ac and Satori Health and Wellness may collect, use and disclose my personal information in the manner set out above, and in accordance with our privacy policy.

Date: ____________________ ______________________________ ______________________________

Signature of patient/guardian Signature of witness