

Cosmetic Acupuncture
Confidential Health History Form



12 Irwin Ave Suite 200-201, Toronto, ON M4Y 1K9

The information on this form is confidential and will be used to assist your therapist in determining your treatment plan.

Name: _____ Home #: _____

Address: _____ Cell #: _____

City/Province: _____ Work #: _____

Postal Code: _____ Email: _____

YES! it is okay to send periodic e-mails

Height: _____ Weight: _____ Occupation: _____

Date of Birth / / Who can we thank for this referral? _____
DD/MM/YY

What brings you in for cosmetic acupuncture today? _____

Primary Care Physician: _____	Medications/ Supplements	Reason for Taking
Address & Phone: _____	_____	_____
Exercise / Physical Activity: _____	_____	_____
_____	_____	_____
Frequency: _____	_____	_____

Cosmetic & Cellulite Acupuncture

While cosmetic acupuncture (both facial and cellulite) are relatively new to North America; the theory of Cosmetic Acupuncture is based on the knowledge of Traditional Chinese Medicine (TCM). The concept is by reinforcing the Qi force (the body's natural energy system) it increases the circulation in the body and the face to improve your appearance. Acupuncture can increase collagen production and improved muscle elasticity.

Acupuncture is safe. Depending on the individual bruising may occur. If you are concerned please discuss it with your therapist before treatment.

HEALTH HISTORY: Please indicate conditions you are experiencing, or have experienced in the past:

Please include all information whether you feel it's relevant or not – Remember our muscles hold memories!

General <input type="checkbox"/> Allergies Describe: _____ <input type="checkbox"/> Cancer – Type: _____ <input type="checkbox"/> Diabetes – Type: _____ <input type="checkbox"/> Epilepsy – Type: _____ <input type="checkbox"/> Fainting / Dizziness <input type="checkbox"/> Fatigue / Loss of Sleep <input type="checkbox"/> Fever / Sweats <input type="checkbox"/> Numbness/Tingling/ Loss of Sensation	Head/Neck <input type="checkbox"/> Failing Vision <input type="checkbox"/> Deafness / Hearing Loss / Tinnitus <input type="checkbox"/> Ear Ache / Ear Discharge <input type="checkbox"/> Nose Bleeds – Freq. _____ <input type="checkbox"/> Nasal Obstruction <input type="checkbox"/> Sore Throat <input type="checkbox"/> Gum Trouble / Bleeding <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Jaw Pain / TMJ Dysfunction <input type="checkbox"/> Headaches / Migraines Describe: _____ Frequency: Weekly/ Occasionally/ Stress	Women <input type="checkbox"/> Pregnant Due Date _____ <input type="checkbox"/> # of Pregnancy: _____ Type of Child Birth? _____ <input type="checkbox"/> Miscarriage(s) _____ <input type="checkbox"/> Menstrual Pain <input type="checkbox"/> Irregular Cycle / Excessive Flow <input type="checkbox"/> Cramps and or Backache <input type="checkbox"/> Breast Tenderness / Swelling <input type="checkbox"/> Lumps in Breasts <input type="checkbox"/> Menopause / PMS <input type="checkbox"/> Yeast Infections <input type="checkbox"/> Fibroids / Cysts
Respiratory <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis / Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Smoking: #yrs: _____	Skin <input type="checkbox"/> Eczema/Psoriasis Loc: _____ <input type="checkbox"/> Itchy/ Dry Skin / Rash Location: _____ <input type="checkbox"/> Bruises Easily <input type="checkbox"/> Sensitive Skin <input type="checkbox"/> Warts Location: _____	Cardiovascular <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chronic Congested Heart Failure <input type="checkbox"/> Heart Attack / Angina <input type="checkbox"/> Varicose Veins Loc: _____ <input type="checkbox"/> Phlebitis <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Swelling In Ankles
Genitourinary <input type="checkbox"/> Frequent / Painful Urination <input type="checkbox"/> Kidney / Bladder Infection <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostrate Trouble <input type="checkbox"/> Incontinence	Infectious Diseases <input type="checkbox"/> Chicken Pox – When: _____ <input type="checkbox"/> Mumps / Measles <input type="checkbox"/> Hepatitis A B C <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Infectious Skin Condition Type: _____ <input type="checkbox"/> Other: _____	Gastrointestinal <input type="checkbox"/> Poor / Large Appetite <input type="checkbox"/> Difficult Digestion <input type="checkbox"/> Excessive Belching or Gas <input type="checkbox"/> Constipation / Diarrhea / IBS <input type="checkbox"/> Liver / Gallbladder Trouble <input type="checkbox"/> Acid Reflux / Hiatus Hernia <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Hemorrhoids
Bone / Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> Gout		

Present/Past Involvement in Therapies:

Massage Chiropractic Physiotherapy Naturopathy Acupuncture Osteopathy Other

Injury: _____ **Date:** _____ **Surgery:** _____ **Date:** _____

Nature: _____ **Nature:** _____

Injury: _____ **Date:** _____ **Surgery:** _____ **Date:** _____

Nature: _____ **Nature:** _____

Other Medical Conditions: (digestive or gynecological conditions, hemophilia, hypophilia, anemia, fibromyalgia, SLE)

Of Special Note: (presence of internal pins, wires, artificial joints, pacemaker/similar device, or special equipment):

Updated _____ Updated _____ Updated _____ Updated _____

THANK-YOU for taking the time to complete this health profile. Please ask your therapist if you have any questions.

COSMETIC ACUPUNCTURE

Consent to Treatment Form



12 Irwin Ave, Suite 200/201 Toronto, ON, M4Y 1K9

Under the Health Care Consent Act, 1996 we require your consent prior to commencing any treatments for you. Please print your full name above and sign and date below, after carefully reading this section;

I, _____ understand the information given in the health history form is confidential and will only be used by the therapist for clinical records. The information will be protected by Sage's Privacy Policy and not be released to anyone without my consent.

I acknowledge that my therapist has provided me with such information as is pertinent to the treatment for my primary complaint. Alternative courses of treatment (where applicable and relevant) have been explained to me, as well as the possible risks and side effects, if any.

I hereby request and consent to receive acupuncture for cosmetic purposes by Sage's Acupuncturist. I testify I understand the treatment process and the possibility I may experience bruising and minor bleeding during the course of my treatment. I release Sage and any/all of its therapists from liability for this treatment.

I understand acupuncture and herbal therapy treatments are not intended to take place of medical care or medications. I understand I may discontinue my treatments at any time.

I certify I don't have any of the contraindications for Cosmetic Acupuncture mentioned below.

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Former Plastic Surgery |
| <input type="checkbox"/> Problems with bleeding or bruising | <input type="checkbox"/> Sever Migraines |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | |

I feel I fully understand what is involved in the proposed treatment and provide my full voluntary, informed consent to treatment.

I understand I may be charged for the treatment if I do not call to cancel with 24-hour notice. I also understand if I show up late I may not receive my full scheduled time, however I will pay for the appointment I booked.

Signature

Date

