MYO CENTRE INC.
Massage Therapy & TCM Acupuncture

Acupuncture Intake Form

Name……Date of Birth……

Address……City……Postal Code……

Phone …… Email……

Family Doctor……Occupation……

Medications……

Other treatments undergoing……

HEALTH HISTORY

Please list your health concerns in order of importance:

……

……

Any surgeries or hospitalized history?

……

……

Any hypersensitivity/allergy to food, medications, herbs?

……

……

Any history of fainting? **Yes** ☐ **No** ☐ Is your visit today the result of an injury or accident? **Yes** ☐ **No** ☐

Please give a **24 hour notice for ALL CANCELLATIONS** so we can fill that empty spot. It is our Policy to **CHARGE 50%** of your booked treatment if you do not give us the aforementioned notice.

We offer **EMAIL REMINDERS** only of your appointments direct to your PC or Smartphone

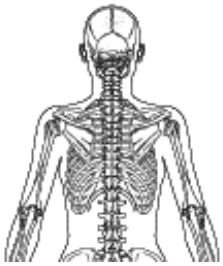
Please **CANCEL** appointments **ONLINE** **Call** 780 451-9290 or **Email** myoctr@telus.net

I, the undersigned, hereby certify that all the information on this form is complete and accurate. I agree to pay MYO CENTRE INC. all outstanding monies owing for acupuncture treatments received at the above mentioned clinic, should my insurance company not pay within 90 days of the original invoice date. I give my permission to receive acupuncture treatments. I have read the above information and agree to its conditions.

Permission to contact you? **Yes** ☐ **No** ☐

Signature……Date……

How did you hear about us?_____



FOR YOUR HEALTH SINCE 1995

C.Wyrozub, RMT, CEO

Follow up Form

Patient Name: _____ Date: _____

Main Complain:

_____

_____

_____

Previous Symptoms Progress:

_____

_____

_____

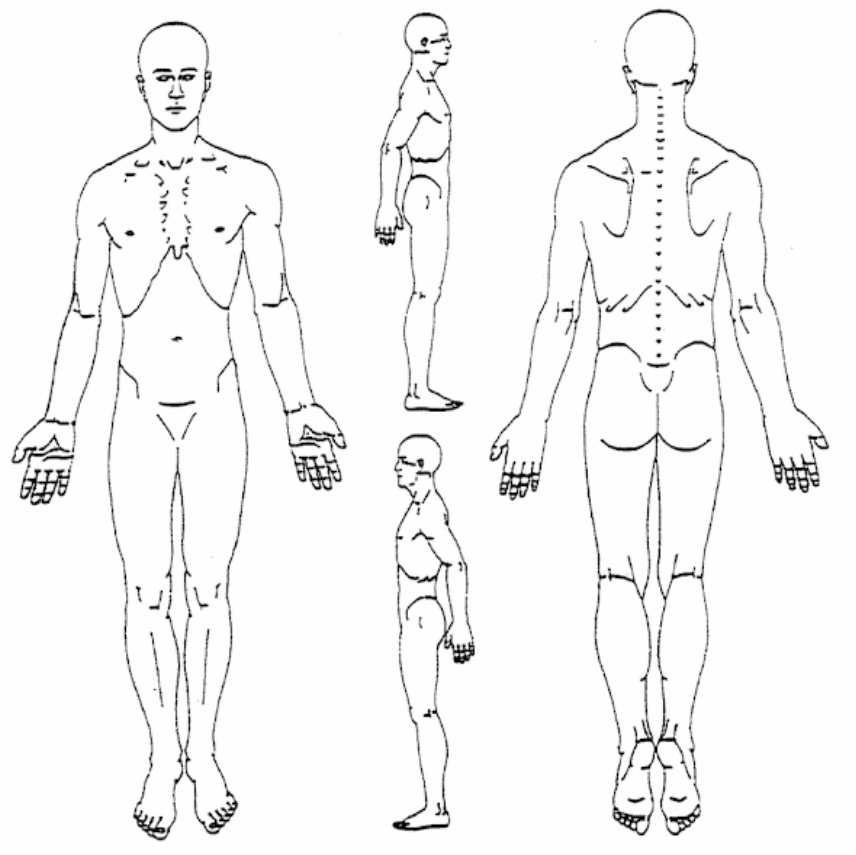
New Symptoms:

_____

_____

_____

Symptoms/Intensity/Duration/Frequency/Onset:



Pulse:

L

R

Tongue body/coating:

TCM Diagnosis:

_____

_____

_____

Treatment Plan:

_____

_____

_____

Points Selections:

_____

_____

_____

_____

_____

Additional Techniques:

Acupressure/Tuina Cupping Moxibustion TDP Other_____

Treatment Note:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____

Initial Consultation Form

Patient:	Date:
Chief Complaint:	Temperature:
Medical History:	Sweating:
Head/Face/Body:	Ears & Eyes:
Food & Taste:	Thirst and Drink:
Chest/Abdomen:	Sleep:
Limbs:	Stool & Urine:
Emotional Symptoms:	Women Symptoms:
Tongue:	Sexual Symptoms:
Pulse:	TCM Diagnosis:
Treatment Principle/Plan:	Points Selection & Treatment Notes:

Signature: _____

Consent Form

I _____, voluntarily request and consent to be treated with Acupuncture (or on the patient named below, for whom I am legally responsible) by the (Acupuncturist/TCM Doctor). I understand that the methods of treatment used in this practice may include, but are not limited to Acupuncture, Acupressure, Moxibustion, Cupping, Guasha, Electrical Stimulation, Plum Blossom Needle, Bleeding, Herbal Therapy, and Dietary Counseling.

I understand that acupuncture is performed by insertion of needles through the skin at certain points on or near the surface of the body in order to treat bodily dysfunctions or diseases as per Traditional Chinese Medicine, to modify or prevent pain perception and to normalize the body's physiological functions. I also understand that no guarantees concerning its use and effects are given to me and that I am free to discontinue treatment any time.

I have been made aware that certain adverse side effects may result from treatment. There may include, but not limited to some bruising, minor bleeding, fainting, temporary pain, or discomfort and possible temporary aggravation of symptoms.

I will notify the Acupuncturist/TCM Doctor in the clinic if I become pregnant or if I am in the process of trying to get pregnant so that points and/or herbs that could induce miscarriage, or otherwise threaten or complicate the pregnancy or becoming pregnant can be avoided.

I acknowledge that I have, as stipulated under section 8 (1) of Alberta's acupuncture regulations, made my health concerns known to a licensed physician or dentist before commencing Acupuncture or other procedures within the scope of the practice of Acupuncture.

I understand that the Acupuncturist/TCM Doctor may review my patient record and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I recognize that by scheduling an appointment, time has been reserved specifically for me, and the (Acupuncturist/TCM Doctor) appreciates 24 hours' notice to reschedule or cancel my appointment, otherwise additional charges may apply in the event of "last minute" cancellation.

By signing this document, I hereby certify that I have read to me, that above consent to the treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to the provision described above. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I fully understand all the above information and I am fully aware of what I am signing.

Patients' Printed Name: _____ Date: _____

Patients' Signature: _____