Toronto AcuBirthing
easing transitions from pregnancy to motherhood

torontoacubirthing.ca
647.258.9471

Patient Info & Medical History

Date of Initial Treatment (dd/mm/yy): ___ /____ /____

Client Name Last Name:	First Name(s):
Date of Birth: (dd/mm/yy): ___ /____ /____ Country of Birth: Years in Canada: Estimated Due Date: (dd/mm/yy): ___ /____ /____	Sex: _____ Identifies as: _____

Contact Info			
Address:	City:	Province:	Postal Code:
Telephone: (c) (h) (w)		Email:	
Occupation:			
Physician: (Name) (Phone) (Address)			
Obstetric Primary Care Provider: (Name) (Phone) (Address)			
Doula/Birth Partner:	Who can we thank for referring you?		
Emergency Contact: (Name) (Phone) (Relationship)			

Medications/Supplements	Reason	Date Started	Dosage	Side Effects

List any Surgeries/Hospitalization/Injuries/Accidents DESCRIPTION	**Month/Year**

Health History **Have you experienced any of the following? Please check all that apply. C=current P=previous**					
Abscesses	❒C ❒P	Epilepsy	❒C ❒P	Multiple Sclerosis	❒C ❒P
Acne	❒C ❒P	Fatigue	❒C ❒P	Nosebleeds	❒C ❒P
Alcoholism/Addiction	❒C ❒P	Fibromyalgia	❒C ❒P	Ovarian Cysts	❒C ❒P
Allergies	❒C ❒P	Flu	❒C ❒P	Palpitations	❒C ❒P
Anemia	❒C ❒P	Gall Stones	❒C ❒P	Parasites/Worms	❒C ❒P
Anxiety	❒C ❒P	Genital Herpes	❒C ❒P	Parkinson's	❒C ❒P
Arthritis (Type) _____	❒C ❒P	Glaucoma	❒C ❒P	Pelvic Inflammatory Disease	❒C ❒P
Asthma	❒C ❒P	Goiter	❒C ❒P	Pleurisy	❒C ❒P
Athlete's Foot	❒C ❒P	Gout	❒C ❒P	Polio	❒C ❒P
Back Pain	❒C ❒P	Hay Fever	❒C ❒P	Pre-eclampsia	❒C ❒P
Bell's Palsy	❒C ❒P	Headaches	❒C ❒P	Prostate Disease	❒C ❒P
Bleeding Disorder	C ❒P	Heart Disease	❒C ❒P	Psoriasis	❒C ❒P
Bronchitis	❒C ❒P	Hemorrhoids	❒C ❒P	Respiratory Disease	❒C ❒P
Cancer _____	❒C ❒P	Hepatitis	❒C ❒P	Rheumatic Fever	❒C ❒P
Canker Sores	❒C ❒P	HIV	❒C ❒P	Rosacea	❒C ❒P
Chronic Cough	❒C ❒P	Hypertension	❒C ❒P	Scarlet Fever	❒C ❒P
Chronic Fatigue Syndrome	❒C ❒P	Infertility	❒C ❒P	Shingles	❒C ❒P
Chicken Pox	❒C ❒P	Insomnia	❒C ❒P	Styes	❒C ❒P
Cold Sores	❒C ❒P	Irritability	❒C ❒P	Strokes	❒C ❒P
Depression	❒C ❒P	Jaundice	❒C ❒P	Thyroid Problems	❒C ❒P
Diabetes (Type) _____	❒C ❒P	Joint Pain	❒C ❒P	Tonsillitis	❒C ❒P
Digestive Problems	❒C ❒P	Kidney Disease	❒C ❒P	Tuberculosis	❒C ❒P
Ear Infections	❒C ❒P	Kidney Stones	❒C ❒P	Uterine Fibroids	❒C ❒P
Eating Disorders	❒C ❒P	Liver Disease	❒C ❒P	Urinary Tract Infections	❒C ❒P
Eczema	❒C ❒P	Low Blood Pressure	❒C ❒P	Yeast Infections	❒C ❒P
Edema	❒C ❒P	Lupus	❒C ❒P	Other:	❒C ❒P
Endometriosis	❒C ❒P	Migraines	❒C ❒P		❒C ❒P

Family Health History

Women's Health:			
Start date of last menstrual cycle:	Age of first menses:	# of Pregnancies:	# of miscarriages / abortions:

Lifestyle (Check any of the following that you currently use & indicate how long & frequently you use them.)	
❒Alcohol	❒ Recreational Drugs
❒Coffee	❒ Laxatives
❒ Tea	❒ Antacids
❒ Tobacco	❒ Pain relievers
What do you do for exercise? How often?	Are your energy levels low/average/high/fluctuating?
OFFICE USE: C/I and Red Flags:	

Patient Informed Consent to Treatment

I have discussed with my Traditional Chinese Medical (TCM) Acupuncturist the specifics of my assessment and/or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to TCM Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Traditional Chinese Medicine include the use of sterile, single-use needles to penetrate the skin. Treatment methods can include, but are not limited to: acupuncture, acupressure, the electrical stimulation of needles, cupping, moxibustion, gua sha, and Tui-na. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.
2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to: slight pain, light-headedness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.
3. I will inform my practitioner if I currently have or develop major health issues, if I suffer from any type of major bleeding disorder, or if I use a pacemaker.
4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious agents, including but not limited to HIV, TB, Hepatitis.
5. I understand that there are no guarantees for the results for the results of my treatments. TCM Acupuncture does not often provide an instant cure. The length of my treatment depends on the severity of my condition. In some cases my symptoms may temporarily worsen before they begin to improve.
6. I understand that the fees charged for for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.
7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.
8. Please inform your TCM acupuncturist if any of the following apply to you:
    - You are prone to dizzy spells or fainting
    - You are pregnant
    - You have a bleeding disorder
    - You are taking anti-coagulants, analgesics or any other medication
    - There are any areas of your body that you are not comfortable being treated directly

Patient Name: _____

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Collect and Release Information

I, _____, or my appointed representative _____

☐ Consent ☐ Do not consent

For Toronto AcuBirthing to collect and release my general patient or medical information to other medical practitioners or health care providers/ support workers, emergency personnel and/or any other relevant organization.

In terms of information, Toronto AcuBirthing may collect any of the following:

- Contact information
- Personal or family medical history
- Medical Insurance or billing/ account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How Your Information Will be Used

Your personal information may be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3rd party insurance companies with insurance claims
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings

Acknowledgment

I allow for medical personnel to use and disclose my information as outlined above.

I understand that I can access my personal health information except as outlined above.

I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive.

My personal information can still be used/ disclosed if mandated by law.

Patient Signature _____ Date: _____

Witnessed: _____ Date: _____