The following information is confidential and required prior to receiving any service.

**We do not accept clients who are pregnant. **

Patient Information form (Please Print)

Name: Date of Birth:

Address: Postal Code:

Phone: (H) (W) (Cell)

Email

How did you hear of us:

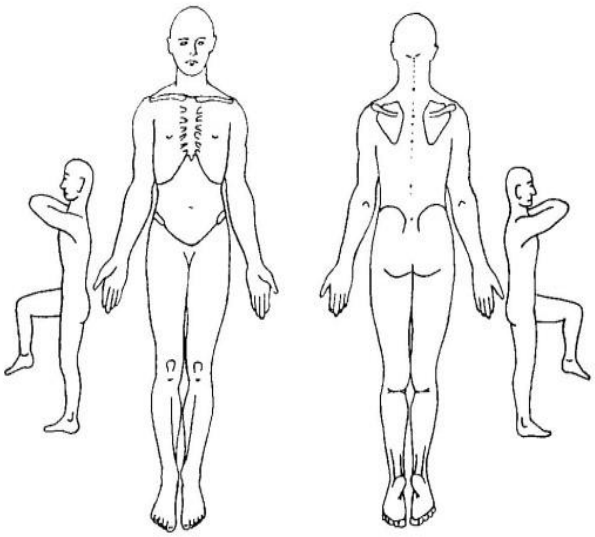
Would you like to join our newsletter? (please check) Yes ____ No ____

Family Doctor: Tel:

Emergency Contact Name: Tel:

What benefits would you like to get from receiving acupuncture or laser?

Do you have pain? Please circle.



Constant ( ) Comes & Goes ( ) Fixed ( ) Moves ( )
Unilateral ( )
Dull ( ) Sharp ( ) Burning ( ) Aching ( ) Spastic ( )
Numb ( )
Better: Heat ( ) Cold ( ) Motion( ) Rest ( ) Pressure ( )
am / pm
Worse: Heat ( ) Cold ( ) Motion ( ) Rest ( )
Pressure ( ) am / pm

SCALE 0 1 2 3 4 5 6 7 8 9 10

Medical History

Is there any possibility you may be pregnant?

if so, how far along are you?

How is your stress level? Please circle: 1 2 3 4 5 6 7 8 9 10 Highest

Current Medications (prescription & over the counter), Supplements, Herbs or Homeopathic Remedies

How was your general health as a child?

Are you a Smoker?

How long have you been smoking?

How much do you smoke in a day?

Have you tried to quit smoking before? YES or NO

When was the last time you tried to quit?

What method have you tried before?

Gum ( ) Patch ( ) Zyban ( ) Champex ( ) Hypnosis ( ) Cold Turkey ( ) other

How long did you quit for?

Do you Frequently Experience Any of these Emotional Behaviors:

Anger ( ) Anxiety ( ) Bitterness ( ) Depression ( ) Stress ( ) Fear ( ) Impatience ( ) Impulsiveness ( )

Irritability ( ) Jealousy ( ) Mood Swings ( ) OCD ( ) Over Excitement ( ) Worry ( ) Sadness ( )

How is you energy level ?

When is your energy at its highest level?

Lowest level?

When was the last time your energy was consistently good?

What are your typical eating habits?

Skip Meal(s) _____ Eat in a Rush ( ) Eat When Not Hungry ( ) Eat too Fast ( ) Eat Late at Night ( )

Cannot/Can eat when Worried/Stressed ( ) Excess Hunger ( ) No Desire to Eat ( )

How much do you consume per day of?

Water ____ Coffee ____ Tea ____ Soda ____ Alcohol ____ Cigarettes ____ Other_____

Do you like: Cold Drinks ( ) Warm Drinks ( ) Room temperature drinks ( )

Craving specific food(s)

Do you have any comments about you diet

Do you exercise? If so, what type of Exercise?

How often? (per week, per day)

What is your approximate: Height Weight

Are you concerned about weight gain? YES or NO

Do you have difficulty falling to asleep or staying asleep?

Do you fell rested upon waking?

Do you have a contagious disease at this time? (ie. hepatitis, T.B, the Flu, HIV etc.)

Do you have: Pacemaker ( ) Cancer ( ) Seizures ( ) Heart Conditions ( ) Surgical Replacements ( ) Implants ( ) High blood Pressure ( ) Hemophilia ( ) Sensitive Skin ( ) Fear of Needles ( ) Latex Allergy ( ) Nut Allergy ( ) Other Allergy _____

Have you ever been Hospitalized? Or had any surgeries? If so what was the reason, and the date?

Is there anything you want to tell me?

Consent Form

I, _____ hereby consent to treatment, namely the use of acupuncture, herbs, nutritional supplements and/or other forms of physical therapy (ie: low level laser acupuncture*, cupping, moxibustion, massage, acupressure, etc.) to be performed by Scosha Diamond, CMAAC #2007-16.

I understand that:

- I agree to undergo said treatments at my own risk. Such risks might include complications, injury or even death.
- No guarantee can be made with regards to results or cure.
- I have the right to consent to or refuse any treatments.
- I am responsible for giving notification in the event I will be late or must reschedule my appointment (24 hour cancellation policy). I understand that if I cancel my appointment the DAY OF, I will be charged a $30 fee. If I do not show for my appointment, I will be expected to pay the FULL PRICE of the service I was scheduled for.
- Ms. Diamond may exercise judgement in the event of an emergency or any unforeseen circumstances that may arise.
- Payment is require at the end of each treatment (unless arrangements are made beforehand).

I have read and understand the above Consent for Treatment.

Signed this _____ day of _____, 20____

Signature: _____

Witness: _____

*Low-Level Laser Acupuncture, also known as cold laser, uses low-intensity lasers and light emitting diodes (LEDs) at the infrared and visible red & ultra blue nM wavelengths. Low Level Laser Acupuncture is safe to use as the cold laser is an infrared tonifying light, while the other cold laser is a ultra blue sedation light. Both are FDA tested and used by many Health Professionals. Both lasers are used to assist a variety of acute and chronic pain conditions. Laser Acupuncture is painless, non-invasive and relaxing.