Dr. Dale Macdonald & Associates
ELITE SPORTPERFORMANCE

ACUPUNCTURE PATIENT INFORMATION FORM

LAST NAME:_____ FIRST NAME_____

ADDRESS_____

CITY_____ POSTAL CODE_____

TELEPHONE: HOME_____WORK_____CELL_____

SEX: MALE ☐ FEMALE ☐ DATE OF BIRTH: M_____D_____Y_____ AGE:_____

OCCUPATION:_____ HEALTH CARE # _____

EMAIL ADDRESS_____

PHYSICIAN'S NAME, ADDRESS & PHONE NUMBER_____

_____

Is this a workplace injury? Yes / No *Please be advised that we do not accept WCB cases.

Is your injury the result of a motor vehicle accident? Yes / No. If yes, additional intake forms are required.

Whom can we thank for your referral? We would like to send them a token of our appreciation._____

DO YOU HAVE REASON TO BELIEVE YOU MAY BE PREGNANT? YES ☐ NO ☐

STARTED DATE OF THE CURRENT SYMPTOM:_____

PREVIOUS MEDICAL VISITS FOR YOUR CURRENT SYMPTOM: **ACUPUNCTURIST CHIROPRACTOR PHYSICIAN RMT**

OTHER_____ (PLEASE CIRCLE)

WHAT WAS THE DIAGNOSIS OF YOUR CURRENT SYMPTOM:_____

SURGERY: YES ☐ NO ☐ WHEN/WHERE:_____

WHEN/WHERE:_____

ARE YOU TAKING MEDICATION? YES ☐ NO ☐ MEDICATION NAME:_____

MEDICATION NAME:_____

FEES include the GST

Initial Consultation: $ 113 Regular Office Visit: $ 93 Missed Office Visit: $62 (<24 hours' notice)

In consideration of your practitioner and fellow patients, *24 hour notice of change of appointment or cancellation* must be given or a fee will be charged. _____ (initial)

SIGNATURE:_____ **DATE:**_____

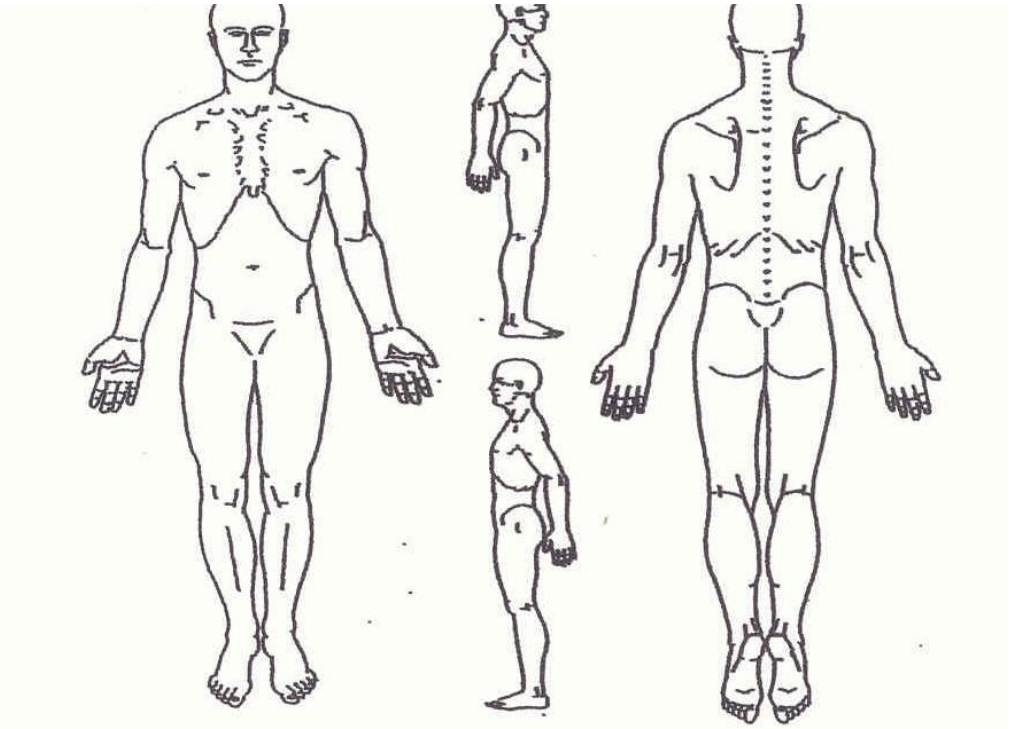
Using the line scale provided below: Rate the pain you are experiencing NOW!

No Pain 0====1======2======3======4=====5======6======7======8======9======10 Severe Pain

DRAWING OF AREA(S) OF CONCERN

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas

Pain area(s)	Ache	Numbness	Pins and Needles	Burning	Stabbing
	\\\\\	++++++	oooooooo	bbbbb	sssss
	\\\\\	++++++	oooooooo	bbbbb	sssss



MAJOR COMPLAINT:

_____

_____

_____

_____

WHAT RELIEVES THE PAIN?_____

_____

WHAT AGGREVATES THE PAIN?_____

_____