

PATIENT HEALTH INFORMATION FORM

(ALL PERSONAL INFORMATION IS STRICTLY CONFIDENTIAL)

Last name:	First:	Middle:	Sex:	Birth date: mm/dd/yyyy
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /
Street address:		Home phone No.:		Mobile phone No.:
City:	Province:	Post Code:	Emergency Contact & Telephone no.:	
CareCard No.				
Occupation:		Family doctor & telephone:		
Referred by:		Email:		
<p>Health Questionnaire: (Please check if you have any of these below)</p> <p>Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV positive <input type="checkbox"/> Hypertension <input type="checkbox"/> Pace-maker <input type="checkbox"/> Blood thinner <input type="checkbox"/></p> <p>Kidney disease <input type="checkbox"/> High/Low Blood pressure <input type="checkbox"/> Cancer Liver/Gall Bladder problem <input type="checkbox"/></p> <p>If you have any allergies, please indicate</p>				
<p>Have you received acupuncture treatment in the past? <input type="checkbox"/> Yes. <input type="checkbox"/> No.</p> <p>Have you received Chinese massage treatment in the past? <input type="checkbox"/> Yes. <input type="checkbox"/> No.</p> <p>Date of last massage:</p>				
Please describe your physical complaint:				
<p>Treatment Consent Waiver:</p> <p>I, _____, undersigned, do hereby give consent to treatment with acupuncture, Chinese massage, and cupping by Shuqin Zhou. The nature and anticipated effects of such treatment or designated special procedure have been explained to me by Shuqin Zhou and I understand the explanation.</p>				
Signature _____			Date — / /	