ALL SPORT
HEALTH & PERFORMANCE

Print Client's full name:
_____

Signature: _____ Date: _____

Address: _____Postal Code: _____

Date of Birth: _____ Tel: _____ Email address: _____

Guardian's Signature (if client is a minor):

_____

Print Guardian's Name:

_____

Emergency contact person: _____Tel: _____

AHC#_____

Primary Benefit Company Name:_____

Membership ID #:_____ Policy/Group#_____

Secondary Benefit Company Name:_____

Membership ID #:_____ Policy/Group#_____

Do you (the client) have any diagnosed medical condition/s? If so which one/s.
_____

_____

Are you currently taking any prescribed or over the counter medication/s? If so which one/s.
_____

_____

Do you have any specific allergies? If so please list which ones.
_____

_____

Family / Hereditary history of health concerns:

_____

_____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently trying to get pregnant? ☐ Yes ☐ No

Please check any that apply:

Cardiovascular

☐ High blood pressure ☐ Low Blood pressure ☐ Irregular heart beat/s ☐ Angina ☐ Palpitations
☐ Chest Pain ☐ Cold hands/feet ☐ Varicose veins ☐ Heart murmur ☐High cholesterol
☐ Bruise easily ☐ Ankle swelling ☐ Difficultly breathing upon lying down

OTHER: _____

Digestive:

☐ Acid reflux ☐ Ulcers ☐ Nausea ☐ Gas/Bloating ☐ Constipation ☐ Diarrhea
☐ Rectal bleeding ☐ Hemorrhoids ☐ Indigestion ☐ Bad breath ☐ Rectal Pain ☐ Poor appetite
☐ Food cravings ☐ Vomiting ☐ Black stools ☐ Abdominal Pain

OTHER: _____

Respiratory:

☐ Bronchitis ☐ Asthma ☐ Regular colds/infections ☐ Excess phlegm
☐ Cough ☐ Breathing difficulty ☐ Poor Immune System ☐ Wheeze
☐ Pneumonia ☐ Pain on breathing ☐ Lung disease

OTHER: _____

Genitourinary:

☐ Bladder infections ☐ Urinary frequency ☐ Urinary urgency ☐ Genital herpes
☐ Frequent urination at night ☐ Incontinence ☐ Genital discharge ☐ Blood in urine
☐ Irregular urinary flow ☐ Kidney stones ☐ Seizures ☐ Increase in volume of urine

OTHER: _____

Neurological:

☐ Poor sleep ☐ Numbness/Tingling ☐ Anxiety ☐ Depression ☐ Poor memory
☐ Seizures ☐ Headaches ☐ Lack of Coordination ☐ Irritability ☐ High Stress levels
☐ Poor concentration ☐ Loss of balance ☐ Migraine headaches

OTHER: _____

Musculoskeletal:

☐ Neck pain ☐ Muscle weakness ☐ Muscle pain ☐ Muscle stiffness ☐ Joint stiffness
☐ Joint pain ☐ Back pain ☐ Broken bones ☐ Back ache ☐ Muscle cramps/spasms

OTHER: _____

Gynecological:

☐ Severe menstrual cramps ☐ Excessive menstrual blood clots ☐ Pain on intercourse
☐ Vaginal discharge ☐ Breast lumps/cysts ☐ Heavy menstrual bleeding
☐ Irregular menstruation ☐ Major pre-menstrual issues ☐ Self breast examination
☐ Regular pelvic examinations ☐ Menopausal ☐ Regular Pap smear test
☐ Vaginal infections ☐ Infertility ☐ Currently pregnant

OTHER: _____

Male Reproductive:

☐ Prostate concerns ☐ Erectile Dysfunction ☐ Impotence ☐ Premature ejaculation
☐ Painful intercourse ☐ Painful ejaculation ☐ Sterility ☐ Low Libido
☐ Sexually transmitted disease ☐ Hernia/s ☐ Testicular concerns ☐ Andropause concerns

OTHER: _____

Endocrine/Hormonal:

☐ Fatigue ☐ Fevers ☐Chills ☐ Night sweats
☐ Excessive thirst ☐ Slow metabolism ☐ Intolerance to heat or cold ☐ Low blood sugar
☐ High blood sugar ☐ Weight loss ☐ Weight gain ☐ Autoimmune disease

OTHER: _____

Skin/Hair:

☐ Rashes ☐ Itching ☐ Poor healing sores ☐ Eczema ☐ Fungal Infections
☐ Acne ☐ Mole/s ☐ Hives ☐ Skin cancer ☐ Loss of Hair
☐ Dandruff

OTHER: _____

Eyes/Ears:

☐ Impaired vision ☐ Eye pain ☐ Cataracts ☐ Blurred vision ☐ Glaucoma
☐ Double vision ☐ Spots in front eyes ☐ Ringing in the ears ☐ Impaired hearing ☐ Ear aches
☐ Dizziness ☐ Vertigo ☐ Ear infections ☐ Ear discharge

OTHER: _____

CONSENTS

“Acupuncture” means the stimulation of a certain point or points near the surface of the body via the insertion of thin needles. The purpose of acupuncture is to prevent or modify the perception of pain and normalization of physiological functions. If often serves in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture, manual stimulation, cupping, Tui Na, and/or moxibustion. The potential benefits: acupuncture may allow for the painless relief of one’s symptoms without the need for drugs and improve balance of bodily energies leading to the prevention of illness, or the elimination of presenting problems.

Use of disposable needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time use needles made of surgical steel needles. After each treatment, they are disposed of as medical waste, needles are never reused. Additionally, your acupuncturist has had training in Clean Needle technique and Universal Precautions.

Potential risks: slight pain or discomfort at the site of needle insertion, infections, bruises, weakness, numbness, fainting, nausea and aggravation of problematic systems existing prior to acupuncture treatment. Cupping almost always causes bruising. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).

By agreeing, I show that I have read the above Patient Information, have been told about the risks and benefits of acupuncture, herbals and other procedures and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____ (Initials)

Herbal Remedies: The herbs and nutritional supplements (which are from plant, animal or mineral sources) that have been recommended are traditionally considered safe in the practice of Traditional Chinese Medicine or Western Herbalism, although some may be toxic in large doses or when mixed with some pharmaceuticals. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify Katherine Talbot if I experience any of the above-mentioned side effects or if I become pregnant. _____ (Initials)

I, the undersigned, hereby acknowledge that Katherine Talbot does NOT give medical advice. I acknowledge that I am seeking custom made alternative health care products and that this brief consultation is not a substitute for the advice of a medical physician. _____ (Initials)

I hereby assume any risks and I do clearly swear that every decision that I make will be of my own free will. I acknowledge that it is my responsibility to inform my medical physician of any recommendations I choose to follow and any products I choose to use as a result of my consultation with Katherine Talbot. I hereby release, hold harmless, and waive all my rights to sue Katherine Talbot for any cause, and for any loss, cost or damage, arising from the services provided to me. _____ (Initials)

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, may be charged a cancellation fee of $50. Same day/NO SHOW will result in a charge of the full appointment.

Signature_____ Date_____