evolve
THERAPEUTIC MASSAGE INC.

First Name: ________________________________ Last Name: ___________________________ DOB: D: ____ M: _____ Y: _______

Address: ____ City: ______________________ Postal Code: _____________

Phone (Mobile): ____________________________ (Home): ___________________________ (Work): __________________________

Emergency Contact: ____ Phone: ____

Occupation: ____ E-mail: ____

Describe your current concern: ____

How and when did it begin? ____

Have you tried acupuncture or Chinese Herbs before? ____

List any current medications: ____

List any allergies: ____

List all treatment you've had for the concern: ____

Do you exercise regularly? ☐ Yes ☐ No List your activity: ____

Do you smoke or vape? ☐ Yes ☐ No For how long: ____

History (check all that apply):

☐ Heart Disease	☐ Hepatitis	☐ High/Low Blood Pressure	☐ Stroke
☐ Lung Disease	☐ Diabetes	☐ Dermatitis	☐ Asthma
☐ Liver Disease	☐ Cancer	☐ Thyroid Disease	☐ Arthritis
☐ Kidney Disease	☐ Seizures	☐ Bleeding Problem	☐ STI
☐ Vision Concern	☐ Allergies	☐ Menstrual Concern	☐ Neurological Condition
☐ HIV/AIDS	☐ Migraines	☐ Tinnitus/Vertigo	☐ Irritable Bowel Syndrome

Do you have any of the following conditions?

☐ Palpitation	☐ Headache/Migraine	☐ Alternating Cold and Hot	☐ Constipation
☐ Chest Pain	☐ Tinnitus/Hearing Issue	☐ Cough (wet/dry/sputum)	☐ Diarrhea/Loose Stool
☐ Heartburn	☐ Dizziness	☐ Dry Mouth and Throat	☐ Bloating/Gas
☐ Poor Concentration	☐ Blurred Vision	☐ Feeling a Lump in Throat	☐ Painful Period
☐ Poor Memory	☐ Dry/Itchy Eyes	☐ Bitter Taste in Mouth	☐ Difficulty Urinating
☐ Irritability	☐ Numbness/Tingling	☐ Belching/Hiccup	☐ Frequent Urination
☐ Depression/Anxiety	☐ Feeling Heaviness	☐ Thirsty Easily	☐ Dry Skin
☐ Tiredness/Low in Energy	☐ Insomnia	☐ Shortness of Breath	☐ Eczema/Skin Rashes
☐ Emotional/Moodiness	☐ Dream Disturbed Sleep	☐ Nausea/Vomiting	☐ Brittle Nails
☐ Hypochondria Pain	☐ Night Sweating	☐ Abdominal Distention	☐ Weak knees/low back
☐ Decreased Libido	☐ Feeling Cold/Hot Easily	☐ Poor/Excessive Appetite	☐ Muscle Pain
☐ Frequent Colds/Flu	☐ Feeling Hot in Hands/Feet	☐ Tendency to Gain Weight	☐ Joint Pain

FOR FEMALES ONLY

Check all that apply and indicate date of onset:

- ☐ Pregnancy____
- ☐ Miscarriages____
- ☐ Abortions____
- ☐ Current period____
- ☐ Duration of period____
- ☐ Days between period_______________________________________
- ☐ Premenstrual tension_______________________________________
- ☐ Excessive Uterine bleeding___________________________________
- ☐ Amenorrhea____
- ☐ Vaginal discharge color_____________________________________
- ☐ Infertility____
- ☐ Uterine Prolapse____
- ☐ Menopausal symptoms_______________________________________
- ☐ Finished Menopause____

I AFFIRM (please initial):

_______ I understand that my personal and medical information is confidential, and will be accessible by practitioners and staff of Evolve Therapeutic Massage Inc., and will only be disclosed to third parties with your written permission or if there is a legal requirement. I certify that the information I provide is true and accurate to the best of my knowledge. I understand that I may revoke this permission in writing at any time in the future. My electronic patient file will remain property of and under the custodianship of Evolve Therapeutic Massage Inc. A patient may request a photocopy of their records for a charge.

_______ Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours' notice of cancellation or changes. For Monday bookings please provide 48 hours' notice. Patients who provide less than the required notice, or miss their appointment, will be charged a cancellation fee. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient (or guardian of patient).

_______ I hereby agree and consent to the performance of acupuncture and related procedures associated within the scope of Traditional Chinese Medicine (TCM), by CTCMA registrant. I understand that such procedures may include but are not limited to acupuncture, moxibustion/infrared heat lamp, cupping, ear seeds, acupressure/Tui-Na massage, electrical stimulation, Low-Level Laser Therapy (LLLT), herbal formula prescription and nutritional counselling based on TCM theory. All needles are packaged one time use needles made of surgical stainless steel.

_______ I have been informed that acupuncture is a safe method of treatment, but may have minor side effects, including bruising, numbness, tingling, minor swelling, bleeding or hematoma at the site of insertion that may last a few days, and in rare cases, dizziness or fainting. There have been rare instances reported of spontaneous miscarriage and pneumothorax. This clinic uses only sterile, disposable needles according to the Clean Needle Technique protocol, to ensure a clean and safe environment. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained or removed. There may be some bruising after cupping that may last a few days. Occasionally there may be increased soreness at the sites of treatments on the day of, or day following acupressure/Tui-na massage treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that while this document describes that major risks of treatment, other side effects and risks may occur.

_______ I am relying on the practitioner to exercise judgment during the course of treatment, based upon facts that known, the treatment plan is appropriate and in my best interests. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

SIGNATURE: ____ DATE: ____________________________