Dr Cindy Tran N.D @ Purity Health and Wellness
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Intake and Consent for advanced injection therapies –

Prolotherapy and Neuraltherapy

Personal Information

Name: _____

Date of First Visit: _____ PHN# _____

Birth Sex: ☐M ☐F Gender Identity: _____ DOB(D/M/Y): _____

Address: _____ City, Province: _____ Postal code: _____

Cell phone #:_____ Home phone#:_____

Email: _____ Confirmation: Email / Phone / Text Message

Emergency Contact:

Name: _____ Relation:_____ Phone #: _____

Health Screening

Please list any current health concerns and or diagnoses:

_____

_____

Surgeries:_____

Medications (current): _____

Known Allergies: _____

Allergy to local anaesthetic: Yes / No Allergy to Latex: Yes / No

Previous diagnoses: (Please check all that apply to you)

- ☐ Bleeding disorders
- ☐ Asthma
- ☐ Arrhythmia
- ☐ Hypertension
- ☐ History of MI
- ☐ Abnormal EKG
- ☐ Peripheral edema
- ☐ CHF
- ☐ Anxiety/Panic Attacks:
- ☐ Pulmonary edema
- ☐ Angina
- ☐ Kidney disease
- ☐ General edema
- ☐ Diabetes
- ☐ Cancer

*Are you currently or potentially pregnant? Yes / No

THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE, ACCURATE, COMPLETE AND UP-TO-DATE TO THE BEST OF MY KNOWLEDGE

Signature: _____ Date: _____

Informed Consent for advanced injections including Prolotherapy and/or Neuraltherapy

I have been informed of the risks and complications of injection therapies, although extremely rare, can be:

1. Pain at the injection site
2. Dizziness, nausea, and/or vomiting
3. Numbness
4. Allergic reaction to active ingredients (i.e. local anesthesia)
5. Toxic reaction to active ingredients (i.e. rapid intravascular injection, chemical synovitis)
6. Infection at the injection site
7. Injury to nerves and muscles at the injection site
8. Temporary or permanent nerve paralysis
9. Spinal cord injury (proximal spinal cord injections)
10. Pneumothorax (lung field injections)
11. Death from complications of treatment

Initials: _____

Statement of acknowledgement and consent

As a patient of Purity Health & Wellness, I _____ have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself in writing or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs.

I hereby consent to treatment from Dr. Cindy Tran, ND, including but not restricted to injection therapies, and intend this consent to cover the entire course of treatment for my present condition. I understand this consent is voluntary and may be revoked at any time.

Printed name: _____

Signature: _____

Date:_____

Cancellation policy

I understand that I am required to give a minimum of **24 hours notice** if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment.

Signature: _____ Date: _____