

*5010-50th Ave Leduc, AB T9E 6T3 Phone: (780) 980 2877*

*5109-50th Ave Wetaskiwin, AB T9A 0S5 Phone: (780) 312 2899*

**PLEASE TELL US ABOUT YOURSELF:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name

Chosen Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Salutation/Pronouns (Optional): \_\_\_\_\_\_\_\_

 (if different from above)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AHC#(Alberta Health Care): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DD/MM/YYYY

Sex (at time of birth): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current gender identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION:**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Number Street Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Apartment Number City Postal Code

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Cell Phone Email

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Phone Number

Have you seen a chiropractor before? (if so, when): Yes ☐ No ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Practitioner**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Phone Number

**BILLING INFORMATION:**

**SECTION 1 WCB:**

Is this a Worker’s Compensation Board Injury? Yes ☐ No ☐

(If NO, skip to section 2)

WCB Claim number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (DD/MM/YYYY)

**Employer’s Information:**

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 2 MVA:**

Are your injuries related to a motor vehicle accident case? Yes ☐ No ☐

(If NO, skip to section 3)

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy or Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (DD/MM/YYYY)

**Insurer’s Information:**

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Agreement for Services**

*I agree to pay for all services performed at Refresh Wellness Centre at the time of service, including but not limited to: Examination, Treatment, and any other Expenses (Herbal Product, Taping supplies etc.)*

***I understand that I am financially responsible for all bills incurred under the care of Refresh Wellness Centre and the Chiropractor providing my care.***

Our office policy states payment must be made in full for all services rendered at the time of visit unless other arrangements have been made at the time of service. If your account is not paid in full within 30 days, you will be responsible for any expenses incurred in the collection process of your account. If you are involved in any type of litigation case i.e.: auto accident, and you choose to discontinue care before the doctor releases you, your balance will be due, immediately.

**Third Party Direct Billing**

I authorize payment of medical benefits to the Chiropractor from which I have received treatment for services rendered. A further assignment of benefits may be needed depending on the insurer. In the event we are unable to direct bill your insurance provider a receipt will be provided for you to submit in your own time. We are unable to direct bill for retail products.

I understand that I am financially responsible to pay Refresh Wellness Centre for all insurance checks that are sent to me from my insurance company for services rendered in this office that were meant for services completed by the treating Chiropractor. In the event reimbursement monies are sent to me instead of the treating practitioner, or should the claim submitted on my behalf be denied I understand I am responsible for payment on my account immediately for all services completed*.*

**Cancellation and Missed Appointment Policy**

Refresh Wellness Centre requires appointment cancellations be received in advance of 24hrs of a scheduled appointment.

Any cancellations received within 24 hrs of a scheduled appointment time will result in a cancellation fee of **$50** charged to your account and payable immediately upon receipt of invoice. **\_\_\_\_\_ (Patient initials)**

Any missed appointments (no shows) will be charged a missed fee at the **full fee** for the appointment missed. This fee is payable immediately upon receipt of invoice. **\_\_\_\_\_\_ (Patient initials)**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to abide by the above policies.

Patient/ Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information Consent**

We are committed to protecting the privacy of our client’s personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances described in this form, we also collect, use, and disclose personal information where permitted or required by law.

We collect information from our clients such as names, home addresses, work addresses, personal and work phone numbers, and email addresses. (Collectively referred to as “Contact Information”). Contact information is collected and used for the following purposes:

* To open and update client files.
* To invoice clients for services or collect unpaid accounts.
* To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
* To send reminders concerning the need for further treatment and/or appointment reminders.
* To send clients informational material about our offices.

Contact information is disclosed to third party health benefit providers and insurance companies where the client has submitted a claim for reimbursement or payment for all or part of the cost of the service or has asked us to submit a claim on the client’s behalf.

We collect information from our clients about their health history and treatments, their family health history, and their physical condition. (Collectively referred to as “Medical Information”). Medical Information is collected and used for the purpose of providing treatment.

Medical Information is disclosed:

* To third party health benefit providers and insurance companies where the client has submitted a claim for reimbursement or payment of all or part of the cost of treatment or has asked us to submit a claim on the client’s behalf.
* To Refresh Wellness Centre practitioners at all locations for client treatment purposes.
* To healthcare professionals such as physicians if the client has been referred by us for treatment.

If we are ever considering selling all or part of our business, qualified potential purchasers may be granted access to client information to verify information important to the potential sale access as part of the due diligence process. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

To comply with the Canadian Anti-Spam Legislation in effect as of July 1, 2014, our office would like to have your express consent to continue communicating with you providing you with important information from us. We are committed to never sending spam emails, and our privacy policy will always protect your electronic information. We do send information and/or communication via email and text for our patients’ convenience. If you decide to opt in and continue receiving emails and texts, you may withdraw your consent at any time.

\_\_\_\_ YES, I give consent to receive communication and appointment confirmations via email and/or text.

\_\_\_\_ No, I do not give consent. I prefer to receive telephone confirmations.

I consent to the collection, use and disclosure of my personal information as outlined above.

Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Symptom Diagram**In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Please draw in the face on the diagram.**Symbols:** |
| Numbness | ======= | Pins and Needles | **ooooo** |
| Burning | **x x x x x x** | Stabbing & Sharp | **~~~~~** |
| Dull & aching | **? ? ? ? ? ?** | Stiff & Tight | **2 2 2 2 2** |





**Health Questionnaire**

Present Symptoms: Please ✓the box for any conditions or symptoms currently causing you problems. Past Symptoms: Please X the box for any conditions or symptoms that you have had in the past.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gastrointestinal*** Poor appetite
* Indigestion
* Excess hunger
* Belching or gas
* Vomiting
* Pain over stomach
* Constipation
* Hemorrhoids

(piles)* Jaundice
* Gall bladder

trouble* Intestinal worms
* Ulcer
* Diabetes
* Diarrhea
 | **General Symptoms*** Loss of

Consciousness* Blackouts
* Headache
* Fever
* Excess Sweating
* Night sweats
* Loss of Weight
* Night pain
* Generalized pain
* Convulsions

G**enitourinary*** Trouble urinating
* Blood in urine
* Kidney infection
* Bedwetting
* Prostate trouble
 | **Muscles & Joints*** Sore/stiff neck
* Low back pain
* Mid back ache
* Painful tailbone
* Shoulder pain
* Arm/forearm pain
* Elbow pain
* Wrists/hand pain
* Hip pain
* Knee pain
* Ankle/foot trouble
* Arthritis
* Loss of strength
 | **Eyes/Ears/Nose/Throat*** Failing vision
* Eye pain
* Failing hearing
* Earache
* Ring/buzz in ears
* Frequent colds
* Sinus infection
* Enlarged thyroid
* Enlarged glands
* Nervousness
* Convulsions
 | **Respiratory*** Asthma
* Chronic cough
* Spitting up phlegm
* Spitting up blood
* Difficulty breathing

**Skin*** Rashes/itching
* Bruise easy
* Dryness
* Boils
* Hives (allergies)
 |
| **Neurologic*** Dizziness
* Fainting
* Problem speaking
* Problem

swallowing* Blurred vision
* Double vision
* Clumsiness
* Numbness or

tingling**Cardiovascular*** Bleeding disorder
* High blood

pressure* Chest pain
* Stroke
* Hardening of

arteries* Varicose veins
* Swelling of ankles
* Poor circulation
* Heart/blood

disease* Angina
 | **Menstrual related*** Painful menstruation
* Excessive flow
* Hot flashes
* Irregular/absent

cycle* Cramping/backache
* Abnormal vaginal

discharge* Swollen breasts
* Lump in breasts

**Have you had a bone density scan?*** Yes □ No

**Currently on birth control?*** Yes □ No

**Previously on birth control?*** Yes □ No

**Number of pregnancies:** **Number of****children:**  | **Have you ever had any fractures?*** Yes □ No

If yes - where?**Have you ever been in a car accident?*** Yes □ No

If yes - when?**Have you ever been hospitalized?*** Yes □ No

If yes – why/ when? **Are you currently a smoker?*** Yes □ No

If yes – how much? **Did you previously smoke?*** Yes □ No

If yes – how much?  | **Have you ever been diagnosed with:**Cancer □ Yes □ No HIV/AIDS □ Yes □ No Hep A/B/C □ Yes □ No**Have you ever had any mental health issues?*** Depression
* Anxiety
* Nervousness
* Trauma related condition
* Substance related condition
* Personality disorder
* Bipolar disorder

Other (please list):**Medications (please list):****Clinician comments and signature:** |