

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

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Alternate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Would you like to receive our newsletter via e-mail? YES/ NO (circle one)*

Date of birth: (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for taking the time to complete this questionnaire, feel free to ask any questions that you may have.*

**Your Health History**

Reason for your visit today (Chief Complaint):

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

Is this injury work related? Yes/No

Is the injury a result of a motor vehicle accident? Yes/No

What other treatments have you tried? What have you tried that has helped?

Massage Physiotherapy Chiropractor Other

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

How does it feel in the morning?

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

How does it feel at night?

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

Have you had any surgeries, or have you been hospitalized within the last 5 years?

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

Allergies (Medication, Herbs, Food, or anything else):

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

Major injuries (broken bones, sprain, strain, tears etc.)

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

Prescription medications, vitamins, and supplements:

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

**Aches & Pains**

**Please indicate areas of pain and tightness, tingling or numbness on this diagram:**

******

R

R

L

L

Please mark **on the line** below with an “X” to indicate your current level of pain:

NO pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Most pain

**Circle any of the following conditions you have experienced.**

**Personal and Family History of these diseases? Please write whom (i.e., myself, mom, grandfather etc.) in the box.**

|  |  |  |
| --- | --- | --- |
| Headaches | Heart Condition | Arthritis |
| Back Pain | Diabetes | Asthma |
| Numbness | Stroke | Cancer |
| Dizziness | Osteoporosis | HIV |

**Please circle what you have experienced recently below:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headache/Migraine | Night Sweats | Mood Swings | Spontaneous Sweat | Insomnia |
| Depression | Emotional Distress | Anxiety/Nervousness | Fatigue | Poor Memory |
| Dry Eyes | Tearing Eyes | Hearing Loss | Ringing In Ears | Dizziness |
| Vertigo | Chills/Fever/both | Painful Urination | Incontinence | Frequent Urination |
| Abdominal Noises | Constipation | Diarrhea/Loose BM | Blood in BM | Digestive Problems |
| Palpitations | Joint Pain | Upper Back Pain | Lower Back Pain | Neck Pain |
| Swelling | Bruise Easily | Nosebleed | Fainting | Muscle Pain |
| Cough | Sore Throat | Frequent Cold Flu | Sinus Problems | Swollen Glands |

**For Males**:

|  |  |  |  |
| --- | --- | --- | --- |
| Testicular Pain | Prostate Problems | Impotence | STI |

**For Females**:

Age of first menses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Length of time between each cycle: \_\_\_\_\_\_\_\_\_\_\_\_

Duration of menses: \_\_\_\_\_\_\_\_\_\_\_\_\_Where are you in your cycle now: day\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Painful Periods | Heavy Excess Flow | Regular Cycle/Irregular Cycle |
| Pregnant | Excess Vaginal Discharge | PMS |
| Difficulty with Conception | Miscarriage | Delivery Problems |
| Menopausal | Vaginal Dryness | Painful Sex |
| Breast Lumps | Spotting | Clotting |
| Color: bright red/red/dark red | Flow Texture: dry/normal/watery |  |

**Lifestyle**

How many cups of coffee/tea do you drink a day?

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

Do you smoke? If, yes, how many cigarettes do you smoke in one day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other addictions? If, yes, please specify:

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

Please add any information you think may be useful in treating you today:

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

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

**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 Acupuncturist 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 Registered Acupuncturist 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 Acupuncturist. 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 and 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent**

*Please carefully read the* **Informed Consent for Acupuncture Care**

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including needling, moxibustion, cupping, gua sha, auricular acupuncture, electro acupuncture and other techniques within the scope of practice of an acupuncture treatment. These procedures may only be performed by the Registered Acupuncturists working at Refresh Wellness Centre in Wetaskiwin or Leduc, Alberta.

I have had the opportunity to discuss with the Acupuncturist the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of acupuncture, even though all needles are pre-sterilized and disposable there are some risks to treatment including, but not limited to: soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise judgment during the course of the procedures which the practitioner feels at the time based upon facts then known, are in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

**Doctor/Patient Consultation**

Although a referral is not required for treatment of Acupuncture, Section 8(1) of Alberta’s Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care of a person unless that person consulted with a physician or dentist, for a dental pathology, about the condition for which treatment is being sought and has informed the acupuncturist about this consultation. It is also stated that the acupuncturist must complete a patient consultation form.

All written documentations are confidentially held at Refresh Wellness Centre and may be released for a fee upon written request from the patient or legal guardian.

At Refresh Wellness Centre we are here to help you achieve your optimum health potential and keep it that way for life. That is our primary concern.

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

Name (please print)

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal guardian (under 18 or infirmed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office:**

*Has the patient consulted with a physician or dentist (as appropriate) about the condition for which Acupuncture treatment is now being sought?*

*Yes\_\_\_\_\_ No\_\_\_\_\_*