

Refresh

WELLNESS CENTRE

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

Name: _____ Today's Date: _____

Address: _____ Postal Code: _____

Phone: (Home) _____ (Cell) _____ (Alternate) _____

Email: _____

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

Date of birth: (D/M/Y): _____

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:

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

Do you have any contagious diseases at this time? (i.e. Hepatitis, Flu, TB, HIV, etc.)

Have you had any surgeries, or have you ever been hospitalized?

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

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

Prescription medications, vitamins, and supplements:

Circle any of the following conditions you have experienced. Family History of these diseases? Please write whom (i.e. 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 Nervous	Fatigue	Poor memory
Dry eyes	Tearing Eyes	Hearing Loss	Ringling 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	Low back pain	Neck pain
Swelling	Bruise easily	Nose bleed	Fainting	Muscle pain
Cough	Sore throat	Frequent cold flu	Sinus problems	Swollen glands

For Males:

Testicular pain	Prostate problems	Impotence	STI
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For Females:

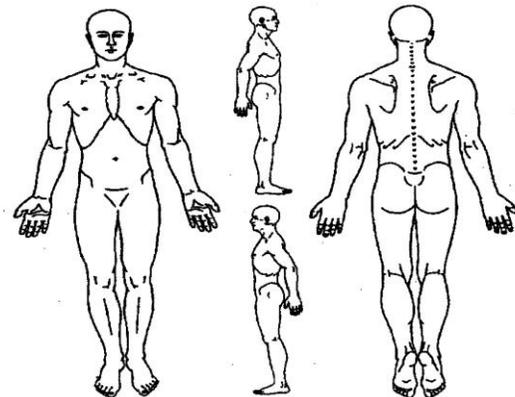
Age of first menses: _____ Length of time between each cycle: _____

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	

Aches & Pain

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



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

NO pain _____ Most pain

Lifestyle

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

Do you smoke? If so how many cigarettes do you smoke in one day?

Do you have any other addictions? If so please specify:

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

Informed Consent

*Please read carefully 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, 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.

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.

There is a \$30 returned check fee for all returned checks that will be added to your bill.

Refresh Wellness Centre requires 24 hours of notice for cancelled appointments. Missed appointments or late cancellations may result in a \$25 fee.

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___