CHIROPRACTIC *Health* CENTRE

Acupuncture

Thank you for choosing our team. How did you find out about us? ______________________

Were you referred by a patient who has seen us? Who? ______________________

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ **M** **F**

Phone #: ______________ (H) Address: ______________________

______________ (W) ______________ Postal Code: ______________

______________ (C) Cellular provider: (for text reminders)

E-mail: ______________________ Reminder Pref.: Phone Text E-mail None

Would you like digital receipts? **Y** **N** Would you like to receive news, promos & updates via e-mail? **Y** **N**

Birthday: ______________ (mm/dd/yyyy) Marital Status: **S** **M** **D** **W** **CL** # of children: ______

Occupation: ______________________ Emergency Contact: ______________________

Phone #: ______________________

HEALTH CLAIM INFORMATION

Do you have extended health benefits? **Y** **N** We offer direct billing for the following insurance companies:

Would you like to use direct billing? **Y** **N**

If 'Yes' please provide the following information: ______________________ Benefits Provider

You are encouraged to bring your insurance card ______________________ Plan Member Name

with you to ensure we have the correct information. ______________________ ID#

______________________ Group/Policy/Contract #

*Please note:

a) **Desjardins** only allows for the plan member to receive reimbursement, therefore all fees incurred are still the patient's responsibility.

b) **Manulife** members must first authorize electronic statements through the plan member site in order to be eligible for these services.

TODAY'S VISIT

Reason for appointment: ______________________

How long have you had symptoms? ______________________

How frequent are your symptoms? ______________________

What are the precipitating factors? ______________________

Have you been seeing any other healthcare professionals for this condition? **Y** **N**

Who? ______________________

What diagnosis were you given? ______________________

How does this condition affect your daily life? ______________________

What makes it worse? ______________________ or better? ______________________

Does a relative have similar problems? Who? ______________________

What is the major source of stress in your life? ______________________

Please add any other information you think is relevant to your condition: ______________________

____

CHIROPRACTIC *Health* CENTRE

Acupuncture

YOUR HEALTH HISTORY

Please list any medications you have taken within the last 2 months (Prescription & Non-prescription, including herbs):

____

Please list any surgeries, hospitalizations and/or significant traumas and their dates: ______________

____

Please list any allergies: ______________________________

Do you usually work: indoors outdoors

Occupational stressors (chemical, physical, psychological, etc): ______________________

Do you smoke? **Y** **N** What? __________ How much? __________ Since? ______

Please list any use of drugs for non-medical purposes: ______________________

Do you exercise regularly? **Y** **N** Type/Frequency: ______________________

How many hours do you sleep generally? _______ When do you usually go to bed? __________

Do you drink caffeinated beverages? **Y** **N** If 'Yes', how many a day? ______________

Do you drink alcoholic beverages? **Y** **N** If 'Yes', how often? ______________

How much water do you a drink a day? __________ Do you prefer: warm cold

Are you vegetarian? **Y** **N** Yes, but not strict.

Do you eat a lot of spicy food? **Y** **N** Prefer: sweet spicy sour salty

Please describe your average daily diet (be as specific as possible):

Morning: ______________________________

Afternoon: ______________________________

Evening: ______________________________

Snacks: ______________________________

Height: _______ Weight: _______ Weight last year: _______ Max weight/year: _______

Please mark whether you've experienced these conditions in the past and/or are presently,
and also indicate whether you took medication for these conditions and list the month/year of the diagnosis:

Past	Present		Medication	Date
		Fibromyalgia		
		Thyroid disease		
		HIV/AIDS positive		
		Digestive disorder		
		Breathing problem		
		High blood pressure		
		Cancer		
		Kidney disease		
		Ulcer		
		Arthritis		
		Neuromuscular disease		
		Psychological challenges		

Past	Present		Medication	Date
		Hepatitis		
		Seizures		
		Venereal disease		
		Tuberculosis		
		Heart disease/stroke		
		High triglycerides		
		Lung/pulmonary disease		
		Osteoporosis		
		Diabetes		
		Anemia		
		Gallbladder disease		

CHIROPRACTIC *Health* CENTRE

Acupuncture

Please mark off any symptoms you have experienced recently:

HEAD
- Headaches
- Migraines
- Memory loss
- Concussions
- Dizziness

Other: ___________________

EARS
- Poor hearing
- Ringing
- Frequent ear infections
- Excess discharge

Other: ___________________

THROAT
- Sore throat
- Difficulty swallowing
- Enlarged thyroid
- Dry throat

MOUTH
- Gum problems
- Teeth problems
- Tongue/lip sores
- Jaw clicking/pain
- Unusual taste

NOSE
- Frequent colds
- Sinus trouble
- Allergies
- Nosebleeds
- Drainage

Other: ___________________

CIRCULATION
- Bruise easily
- Cold hands & feet
- Fainting
- Pheblitis
- Varicose veins
- Anemia

Other: ___________________

HEART & THORAX
- Palpitations
- Rapid heart rate
- High blood pressure
- Low blood pressure
- Tightness in chest
- Arteriosclerosis
- Prior heart attack

SLEEP
- Insomnia
- Drowsiness
- Night sweats
- Sleepwalking
- Excessive dreaming
- Not enough sleep
- Easily awoken

Other: ___________________

UROGENITAL
- Frequent urination
- Difficulty urinating
- Frequent UTIs
- Waking to urinate
- Urine retention/scanty
- Dribbling of urine
- Bed wetting
- Pause of flow
- Itching genitals
- Burning urination

Other: ___________________

EYES
- Blurred vision
- Pain
- Dryness
- Redness
- Glasses/lenses
- Eyestrain
- Colour blindness
- Night blindness
- Cataracts
- Spots in vision
- Decreased vision

Other: ___________________

RESPIRATION
- Asthma
- Bronchitis
- Chest pain
- Cough
- Coughing blood
- Difficulty breathing
- Phlegm
- Pneumonia
- Wheezing
- History of smoking

Other: ___________________

SKIN
- Change in hair/skin texture
- Dryness
- Dandruff
- Eczema
- Hair loss
- Hives
- Itching
- Night sweats
- Pimples
- Excessive sweating
- Rashes
- Recent moles

Other: ___________________

EMOTIONAL
- Depression
- Mania/bipolar
- Anxiety
- Mood swings/temper
- Stress
- Sadness/grief
- Guilt/shame
- Fear
- Relationship issues

FOR MEN ONLY
- Prostate problems
- Discharge
- Impotence
- Frq seminal emissions
- Fertility problem
- Ejaculatory problems
- Painful/swollen testes

Other: ___________________

CHIROPRACTIC *Health* CENTRE

Acupuncture

Please mark off any symptoms you have exerienced recently:

GASTROINTESTINAL

- Colitis or IBS
- Stomach pain
- Poor appetite
- Bad breath
- Excessive hunger/thirst
- Belching/heartburn
- Gas
- Abdominal pain/cramps
- Parasites
- Nausea
- Constipation
- Chronic laxative use
- Diarrhea
- Blood in stool
- Black stool
- Hemorrhoids

NEUROMUSCULAR/SKELETAL

- Stiff neck
- Low back pain/weakne
- Shoulder trouble
- Spinal curvature
- Pain between shoulders
- Knee trouble
- Swollen joints
- Painful joints
- Hip pain
- Arthritis
- Hand/wrist pain
- Sprain
- Hernia
- Sciatica
- Numbness/tingling
- Paralysis

Other: ___________________

FOR WOMEN ONLY

- Painful menstruation
- Cramps/backache
- Fertility problems
- Ovarian cysts
- Excessive flow
- Endometriosis
- Light flow
- Clotting
- Irregular cycle
- Hot flashes
- Vaginal discharge
- Fibrocystic breasts
- Breast tenderness
- PMS
- Abnormal bleeding
- Low sex drive

Other: ___________________

# of pregnancies______

# of births ______

# of miscarriages ______

# of abortions ______

# of premies ______

# of c-sections ______

Age of 1st menses ______

Cycle length _________

Birth control? **Y** **N**

Type: _________

Practitioner's notes:

ENERGY LEVEL

- Low energy
- Excessive energy
- Hard to wake up
- Lethargy midday
- Sudden lethargy

FAMILY HEALTH HISTORY

Has any relative had any of the following? Who?

	Relative		*Relative*		*Relative*
Cancer	______________	Diabetes	______________	Hepatitis	______________
Hypertension	______________	Heart disease	______________	Stroke	______________
Alcoholism	______________	Miscarriage	______________	Autoimmune disease	
Asthma	______________	Other:	______________		______________

Ph: 403-277-9339
Fx: 403-277-2447

www.chiro-doctor.com

2713 Centre St NW
Calgary, AB T2E 2V5

Informed Consent for Acupuncture Treatment

I hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures. I understand that such procedures may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha (dermal friction technique), infrared heat lamp, Chinese or Western herbal medicine, and nutritional counseling based on a traditional Chinese medical theory.

Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

Moxibustion is the application of indirect heat by burning a stick of compressed Folium Artesmisiae Vulgaris, commonly known as Mugwort, over acupuncture points.

Cupping utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area. Bruising is a common side effect of cupping, and the bruising can last up to a week.

I have been informed that in all the acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained or removed.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner stop, modify or change the treatment plan.

I acknowledge that I do not have the following conditions:

Pregnancy
Bleeding disorders
Pacemaker
Local infections
Not currently taking anticoagulants

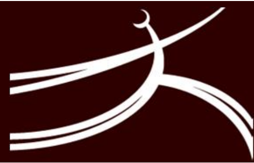
I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

I agree that a photocopy or electronic version of this consent is as valid as the original.

______________________________ Patient/legal guardian signature

______________________________ Printed name

__________ Date



All fees incurred for treatment are payable upon services rendered.
Fee schedule is as follows:

Chiropractic	Massage	Acupuncture
Initial Visit	30 minute.......$45	***Initial Visit***
Adult.......$109	45 minute.......$60	$135
65+ & 12-18.......$89	60 minute.......$80	***Subsequent Visits***
12 & under.......$74	90 minute.......$115	$90
Shockwave.......$175	120 minute.......$135	
Subsequent Visits	Active Isolated Stretch.....$135	
Adult.......$55		
65+ & 12-18.......$44		
12 & under.......$35		
Shockwave.......$125		

Cancellation Policies

We appreciate your decision in making us your choice in health care, please respect the needs of our other patients and make any appointment cancellations in a timely manner. We require ***at least 24 hours notice*** for any appointment changes or cancellations. Any late cancellations or no shows will be billed for the full price of their office visit. This includes any patients that are unreasonably late for their appointment and need to be rescheduled. Please note that these fees will be your responsibility as they are not eligible for reimbursement through any health benefits provider. If care is suspended or terminated, any and all oustanding charges for professional services rendered to or for you will be immediately due and payable to the clinic.

Privacy Policies

We maintain a very high standard for the protection of the confidentiality and integrity of individual personal health information. If any identifying health information is to be released to us for the purposes of providing ongoing care; express written consent will be obtained. If it occurs that your health benefits service provider requires information regarding any of your appointments for any dates in the past, present or future Chiropractic Health Centre reserves the right to provide them with this information. If you have any questions regarding your privacy concerns, feel free to direct any inquiries to the front desk.

I have read and understand the above policies and procedures that are in place and agree to the terms that are defined.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

______________________________ ______________________________

Patient/(Legal guardian) signature: Printed name

____

Date

Electronic Transmission Authorization and Consent

Service Provider:
Chiropractic Health Centre

Consent for Collection and Disclosure of Personal Information

Personal information that we collect in regards to extended health care is disclosed solely for the purposes of determining eligibility and administering the benefits plan, this includes the investigation of fraud and/or plan abuse.

Authorization for the Release of Information

I confirm that I, if not the plan member, am authorized by the individual to release any information regarding them for the aforementioned purposes.

I permit Chiropractic Health Centre to collect, use, and disclose the necessary information needed in the processing of my extended health care claims.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted I acknowledge and agree that my benefits provider and Chiropractic Health Centre may use and disclose any relevant personal information to each other for the purpose of investigation and prevention of fraud and/or plan abuse.

Assignment of Benefits

I agree to assign any benefits that are paid for my eligible claims to Chiropractic Health Centre and authorize my benefits provider to issue payment directly to them. In the event any submitted claim(s) are declined or only partially covered, I understand that I will remain responsible for the cost of the services rendered. If any outstanding balances occur from this and legal action becomes necessary to collect on this amount, I understand that I will be responsible for all attorney and legal fees incurred.

I understand the above terms and agree that this authorization is to apply to all eligible claim(s) submitted electronically by Chiropractic Health Centre, and that I may revoke authorization at any time by providing written notice.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

__________________________________ Patient/legal guardian signature

__________________________________ Printed name

____________________ Date

PRINT SAVE