BURNABY HEIGHTS Integrative HEALTHCARE

Clear Form

Help

Confidential Patient History Form for Acupuncture/Registered Acupuncturist

Name _____ **Occupation** _____

Date of Birth _____ **Phone (H)** _____

(month / day / year) **(W)** _____

(C) _____

Mailing Address

_____

_____

_____

Postal Code_____

Preferred location of contact:

_____

E-mail _____

Care Card _____ **Referring Doctor** _____

How did you hear about Burnaby Heights Integrative HealthCare?

_____

Why are you seeking acupuncture today (by a registered acupuncturist)?

_____

Are you currently involved in an active ICBC or WCB claim? Yes No

Please answer the following questions about your current condition and symptoms:

Describe your current condition: _____

Is this new for you? _____ If not, how often have you experienced this? _____

How did it start? _____ When did it start? _____

What is your current level of discomfort? Slight 1 2 3 4 5 6 7 8 9 10 Severe N/A

What is your discomfort at its worst? Slight 1 2 3 4 5 6 7 8 9 10 Severe N/A

Approximately when was it last at its worst? _____

Is there a time during the day when your symptoms are worse? _____

What do you do to try to alleviate your condition? _____

Does it work for you? _____ What makes it worse? _____

If any, what medications are you taking for your condition? _____

Have you received a diagnosis from a doctor? _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:

Aching **O**

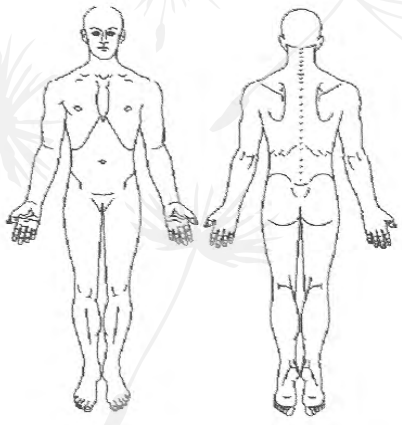
Stabbing **X**

Shooting →

Burning **#**

Numbness **~~**

or Tingling



List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____

_____

_____

Please indicate with a **C** for **Current** and **P** for **Past** conditions that you have or had:

__ High Blood Pressure	__ Dizziness	__ Bruising	__ Crohns/Colitis
__ Heart Conditions	__ Fainting	__ Cold hands/feet	__ Constipation
__ Shortness of Breath	__ Weakness	__ Varicose veins	__ Diarrhea
__ Headaches	__ Concussions	__ Cancer	__ Epilepsy
__ Jaw pain	__ Depression	__ Arthritis	__ Parkinson's
__ Tinnitus	__ Fatigue	__ HIV/AIDS	__ MS
__ Fractures	__ Allergies	__ Diabetes	__ Scoliosis
__ Dislocations	__ Sinus trouble	__ Osteoporosis	__ Stroke
__ Artificial Joints	__ Blurry vision	__ Skin conditions	__ Anxiety

Are you satisfied with your current: (1 = not at all, 5 = completely satisfied)

Ability to work	1 2 3 4 5
Level of exercise	1 2 3 4 5
Diet	1 2 3 4 5
Sleeping patterns	1 2 3 4 5
Energy level	1 2 3 4 5
Emotional status	1 2 3 4 5

Hours of sleep per night (approx.) _____
Number of meals you regularly eat per day _____
Number of times you exercise per week _____

Do you:

Wear orthotics? Yes No If yes, what for? _____
Wear a dental appliance? Yes No If yes, what for? _____
Sleep on your Back Side Stomach

Please list any **major accidents, illnesses or medical procedures.**

_____
_____
_____
_____

Do you take any **medications, herbal supplements or vitamins/minerals?**

Please list:	Reason:
_____	_____
_____	_____
_____	_____

Are you currently receiving treatment from any of the following health professionals?

Doctor___ Naturopath___ Chiropractor___ Physiotherapist___ Acupuncturist___

Have you had massage therapy before? _____ If yes, when? _____

What for? _____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with **24 hours** notice of cancellation, or the appointment fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above.

The information on this form is correct to the best of my knowledge and provides an accurate summary of my past and present medical status. I hereby give my consent to receive massage therapy at Burnaby Heights Integrative HealthCare Inc. and I assume the financial responsibility for all treatments I receive.

Patient (or guardian) signature _____ **Date:** _____

BURNABY HEIGHTS
Integrative
HEALTHCARE

For Patients with Extended Health Benefits
Insurance Providers include: Great-West Life, Sun Life, Standard Life, Johnson Inc., Industrial Alliance, Chamber of Commerce, Maximum Benefit, Manulife, Desjardins, and Blue Cross

Benefit Assignment Form

Insurance Company**:** _____

Patient Name: _____ Date of Birth: _____

Policy Number: _____

Member ID Number: _____

If you are not the insured member, then please provide insured member name and date of birth.

Insured Member Name: _____ Date of Birth: _____

I hereby assign benefits payable for the eligible claims to the **Burnaby Heights Integrative HealthCare, Inc (the Provider)** responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Credit Card: Visa/Mastercard: _____ Exp:_____

Date: _____

Signature: _____ Print Name: _____

BURNABY HEIGHTS
Integrative
HEALTHCARE

Acupuncture Consent. Please Read Carefully and Sign

Please read this information carefully and ask your practitioner if there is anything that you do not understand.
Chinese medicine and its related treatments like acupuncture have proven to be highly effective in correcting and maintaining overall well-being. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects may occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?
• Drowsiness may occur in a small number of patients, and if affected, you are advised not to drive.
• Minor bleeding may occur
• Pneumothorax
• Bruising may occur.
• In some cases (less than 5%) symptoms may become worse (before they improve) for 1-2 days following treatment. This is often a good sign, please advise your practitioner if worsening of symptoms continues for more than 2 days.
• Fainting may occur in certain patients, particularly at the first treatment.

What are the possible side effects from Chinese medicine and other treatments?
• Bruising is a common side effect of cupping.
• All herbs/medicinal substances that will be prescribed are traditionally considered safe in the practice of Chinese medicine and have been approved for use by the Canadian Health Authority.

Is there anything your practitioner needs to know?
It is important to let your practitioner know:
• If you have ever experienced a fit, faint, or other odd detached sensations.
• If you have a pacemaker or any other electrical implants.
• If you are pregnant.
• If you have a bleeding disorder.
• If you are taking anti-coagulants (blood thinners) or any other medication.
• If you have damaged heart valves or have any other particular risk of infection.

What are some policies that may concern you?

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

• Sales Policy: All sales are final and non-refundable.
• Appointment Cancellation Policy: A 24hour notice for change of appointment or cancellation must be given or a fee will be charged.

Dr. Ardis Krueger, ND, Dr. Yalda Godrath-Zadeh, ND Dr. Andrea Watson, DC
Amy Van Sickle, RMT Lisa Nessi, RMT
Barb Sharma, RMT Gina Talio, RMT Karen Grace , RMT You Jung Kim, RMT
Heidi Bagh Khasti, DTCM, RAc, BSN
4353 Hastings Street, Burnaby, BC, V5C 2J7, Tel: 604 293 2941, Fax: 604 298 2941, bhihc.com