Vibrant Life Healthcare

6105 Patricia Bay Highway
Victoria, BC, V8Y 1T4

Patient Name _____ _____ _____
(As it appears on your carecard) **LAST** **FIRST** **MIDDLE**

What name would you prefer us to use? _____

Address:_____ City:_____ Postal Code: _ _ _ - _ _ _

Date of Birth: _____ _____ _____ Age: _____ Gender: _____
MONTH **DAY** **YEAR**

Weight (lbs): _____ Occupation: _____

Contact Information:

Home #: _____ E-mail Address: _____
Cell #: _____
Work #: _____

What is your preferred method of appointment reminders?
□ Phone Call □ E-mail Reminder □ Text Reminder

Emergency Contact:

_____ _____ _____
NAME **PHONE #** **RELATIONSHIP**

How did you hear about our office?
☐ Driving By ☐ Internet ☐ Friend (who?_____) ☐ Other

Are you on MSP Premium Assistance/Disability? YES □ NO □
Please note: There may be $23.00 coverage for Premium Assistance & Disability cases. The remaining portion is due on the date of service.

Were you injured at work? YES □ NO □
Do you have an active WCB claim? YES □ NO □
WCB claim#:_____
* Please notify reception if you have not already if you have a WCB case

Is this an ICBC case? YES □ NO □
ICBC Claim #:_____
* Please notify reception if you have not already if you have an ICBC case

_____ _____
Date of Initial Consultation **Practitioner**

Confidential Patient Health History
Acupuncture and Traditional Chinese Medicine

Please note: Answering these questions informs about your health so the acupuncturist can formulate the most appropriate treatment plan. If you feel uncomfortable answering any of the following questions or would rather tell the practitioner verbally rather than writing it down, you may opt to do so.

Name: _____ Date: ___ / ___ / _____

MAIN CONCERNS

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Please note the year the condition started (if applicable)

	YOU	FAMILY
Cancer *type(s)?* _____	_____	☐
Diabetes	_____	☐
Kidney disease	_____	☐
Blood Pressure High ☐ Low ☐	_____	☐
Heart Disease	_____	☐
Stroke	_____	☐
↑cholesterol	_____	☐
Seizure Disorder	_____	☐
Thyroid Disease High ☐ Low ☐	_____	☐
Asthma	_____	☐

	YOU	FAMILY
Osteoporosis	_____	☐
Liver disease	_____	☐
Communicable/ Infectious disease	_____	☐
**Please specify* _____		
Multiple Sclerosis	_____	☐
Addiction	_____	☐
Allergies	_____	☐
**Please specify* _____		
Mental Illness	_____	☐
Bleeding disorder	_____	☐
Anemia	_____	☐

STRESS (10 is the most stress you've ever been under)

1 ——— 10

HABITS

	Amount / Week	Quit
Coffee / Tea	_____	☐
Soda	_____	☐
Tobacco	_____	☐
Alcohol	_____	☐
Drugs	_____	☐

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
What activities/how often?:

_____
_____
_____

DIET

Do you have a special diet/dietary restrictions?

MEDICATIONS

Please list all medications, herbs or supplements that you take regularly

_____
_____

INJURIES/SURGURIES/TRAUMAS

Please note what, where & when

_____
_____
_____
_____

Please mark an X on the scales and check off any symptoms you have had in the past month

TEMPERATURE

Cold ——— Hot

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Numbness
- ☐ Prefer cold/hot drinks (please circle one)
- ☐ Thirst w/ no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst
- ☐ Unusual sweating (when & where?) _____
- ☐ Excessive sweating
- ☐ Night sweats
- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon/evening

MOISTURE

Dry ——— Oily

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry nose/nosebleeds
- ☐ Dry throat
- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss
- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Edema / Swelling Where? _____

DIGESTION

Diarrhea ——— Constipation

BM/day: _____

- ☐ Loose/soft stools
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Urgency
- ☐ Foul smelling stools
- ☐ Undigested food
- ☐ Poor appetite
- ☐ Gas/bloating
- ☐ Belching
- ☐ Abdominal pain/ Cramping
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger
- ☐ Fluctuating weight

ENERGY

Low ——— High

- ☐ Sudden drop in energy Time of day: _____ am / pm
- ☐ Low energy after eating
- ☐ Fatigue
- ☐ Body/limbs feel heavy/weak
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Ungrounded feeling
- ☐ Bruise easily
- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Frequent headaches

SLEEP

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake frequently
- ☐ Wake to urinate
- ☐ Disturbing/vivid dreams
- ☐ Restless sleep
- ☐ Don't feel rested in AM

EMOTIONS

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES/EARS /NOSE/THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Floaters
- ☐ Sinus congestion
- ☐ Phlegm (*color*_____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting/stopping
- ☐ Incontinence
- ☐ Kidney stones

MENSES

Age at first menses: _____
Length of full cycle: _____ days
Length of cycle: ____ days
Last period start date: ____ / ____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Clots

# of pregnancies: ____
# of births: ____ premature ____
# of abortions / miscarriages: ____

- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Mid-cycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)

Menopause:

Age at last menses : _____
Year changes began: _____
Symptoms: _____

SEXUAL HEALTH

- ☐ Libido: ⇧ ⇩
- ☐ Erectile dysfunction
- ☐ Prostate disease
- ☐ Sexual trauma
- ☐ Infertility

JOINT/MUSCLE/BONE DISCOMFORT

Identify the area and type of pain:
S=stabbing, sharp T=tension
D=dull
F=fixed
R=radiating

Neck ____
Upper back _____
Mid Back _____
Lower Back _____

	L	R
Sciatica	___	___
Shoulders	___	___
Arms	___	___
Hands	___	___
Hips	___	___

	L	R
Feet	___	___
Legs	___	___

Other _____
_____

Office Policies

Payment for examination and treatments are due on the day services are rendered. Your treatments or custom foot orthotics may be covered, or partially covered by ICBC, WCB, MSP or your Insurance Provider. If, for whatever reason, your coverage is denied, then *you are fully responsible for payment of all services rendered.*

- **Please allow us at least 24 hours notice if you are unable to keep your appointment.**
- **If you miss/no-show your appointment, you will be charged the full appointment fee.**

Because many people have allergies to perfumes and other scents, we ask that you refrain from wearing them while in our office.

I understand and agree to the above policies.

_____ _____

Print Name Signature of Patient

Date: _____

Please check

□ I, hereby, give consent to share my health history information among Vibrant Life Healthcare professionals (within their respective scopes of practice) for the purpose of efficient use of clinical resources for the achievement of integrated healthcare for the intended purpose of interprofessional collaboration by all health providers for the overall benefit of my health.

Assignment of Benefits

Some insurance plans allow for direct billing. Please provide the following information so we can bill your plan directly, if applicable to you and keep your information on file.

CARECARD #: _____

INSURANCE COMPANY NAME: _____

PLAN MEMBER NAME: _____

POLICY/GROUP NUMBER: _____

PLAN MEMBER ID #: _____

If you have dual insurance through a spouse or family member, please provide the following:

INSURANCE COMPANY NAME: _____

PLAN MEMBER NAME: _____

PLAN MEMBER DATE OF BIRTH: _____

POLICY/GROUP NUMBER: _____

PLAN MEMBER ID #: _____

I understand that the fees listed in this claim and/or future claims may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to the service provider for the entire cost associated with this claim and/or future claims.

I hereby assign my benefits payable from this claim and/or future claims to Vibrant Life Healthcare and authorize payment directly to them. Vibrant Life Healthcare may bill electronically or manually on my behalf.

I understand that my insurance provider and/or a benefit plan sponsor including; MSP Premium Assistance, reserve the right to modify assignment privileges for specific benefits, benefit categories, specific service providers or service provider categories.

I hereby certify that the information provided in connection with this claim is true, accurate and complete. I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my health or the health of any insured member of my family as it may relate to this claim to release such information to my insurance provider and to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Plan Member's Signature: _____ Date: _____

The Exchange of Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing, and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent

I authorize Vibrant Life Healthcare to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

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.

Plan Member's Signature: _____ Date: _____

INFORMED CONSENT TO ACUPUNCTURE CARE AND TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Traditional Chinese Medicine on me (or on the patient named below, for whom I am legally responsible) by the Registered Acupuncturist.

Acupuncture/ Electro-Acupuncture/ Moxibustion/ Massage/ Cupping/ Gua Sha/Eastern Dietary Therapy

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Gua Sha, and nutritional councelling.
Potential benefits of these treatments may include relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of your main complaint(s).

Although uncommon, Acupuncture may cause temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needle site that may last a few days. Unusual risks of Acupuncture include dizziness, fainting, nerve damage or the aggravation of symptoms existing prior to treatment. Infection is a slight possibility even though the clinic uses only sterile disposable needles and maintains a clean and safe environment. Cupping or burning of moxa on or near the body has the potential risk of burns, blistering or scarring. Cupping and Gua Sha may leave red marks or bruising on the skin temporarily. I will immediately inform the practitioner if I experience any discomfort or adverse reactions and I have the right to refuse treatment, or part of treatment at any time.

I understand that Acupuncturists do not diagnose illness, disease or any physical/mental disorders according to Western medical standards, nor do they prescribe medical treatment or pharmaceuticals. I am aware that Acupuncturists use traditional techniques to identify a pattern of disharmony which is then used to develop a treatment plan. I acknowledge that Acupuncture is not a substitute for medical examination or diagnosis. It is recommended that I see a primary health care provider for that service.

I recognize that scheduling an appointment involves the reservation of time specifically for me and I agree to give at least 24 hours notice to cancel or reschedule an appointment.

I understand that the information I have provided is confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Practitioner's Name	Practitioner's Signature	Date