

Cancellation and Fee Information

Acupuncture and Chinese Medicine

24 hours notice is required for all appointment cancellations or there will be a fee charged, as well as a fee charged for no shows.

(If we are able to fill the appointment spot, the fee will not be charged)

INSURANCE: We are not able to bill WCB, MSP, Extended Health care plans, or ICBC directly, so payment is required at the time of treatment in these circumstances. We do provide receipts for submission.

THIRD PARTY: Veterans, Department of National Defense employees, and RCMP require authorization and a doctor's referral for us to bill directly, otherwise payment is due at the time of treatment. Any missed appointment fees are the responsibility of the patient.

NO SHOW/LATE CANCELLATION FEES:

30min. appt: \$65, 45min. appt: \$75, 60min. appt: \$85

Please note: While we try to call and remind you of your appointment the day before, it is best to **not** rely on reminder calls.

I have read and agree to the above:

Signature

Printed Name

Date

Dr. Stefan Rabnett, R. TCMP

Colwood Back to Back
Acupuncture & Traditional Chinese Medicine

Consent and Information Form

Welcome to Colwood Back to Back. I would like to take this opportunity to share some important information related to your treatment.

Traditional Chinese Medicine and Acupuncture are very effective healing modalities which have been observed, practiced, and perfected over 3500 years. In this system of medicine, the body has been mapped out into a series of pathways, or meridians. Stimulation of specific locations along these meridians has proven to be very effective in treating a wide range of health imbalances. Recently, modern electromagnetic research has confirmed these specific locations. Acupuncture involves the insertion of fine sterile, disposable needles into these points. The needles themselves are of the highest quality, and are often no thicker than a human hair. As such, their insertion often creates little to no discomfort. In fact, once the treatment begins, most people will experience a calm feeling of relaxation.

Although infrequent mild bruising at the insertion site can occur, there is an extremely low rate of adverse affects to acupuncture. British Columbia has extensive training and safety requirements for Acupuncturists and Traditional Chinese Medicine Practitioners. As a result, complications such as pneumothorax or nerve injury are extremely rare. We are, however, required by law to advise you of these risks.

The use of Traditional Chinese Medicine Herbs may be recommended and prescribed according to the patient's needs. Only the finest quality herbs are used in this clinic.

All information related to your file will be kept confidential. The accompanying Comprehensive Health History is designed to determine how to best treat your health concerns. Please answer to the best of your ability. It is my goal to provide a safe, comfortable, and effective environment for your treatments. If at any point you have questions or concerns, please do not hesitate to communicate them with me.

If you are comfortable with the information presented, and you consent to treatment, please sign below.

Signature

Printed Name

Date

Confidential Health History

Personal Information:

Name: _____
Address: _____
Occupation: _____
Phone: Home: _____ Work: _____
Cell: _____ E-mail: _____

Date of Birth: _____ Sex: _____
Relationship Status: _____
Doctor's Name: _____
Doctor's Phone # (if known): _____
Emergency Contact:
Name: _____ Ph #: _____
Referred By: _____

Present Condition:

Chief Complaint:

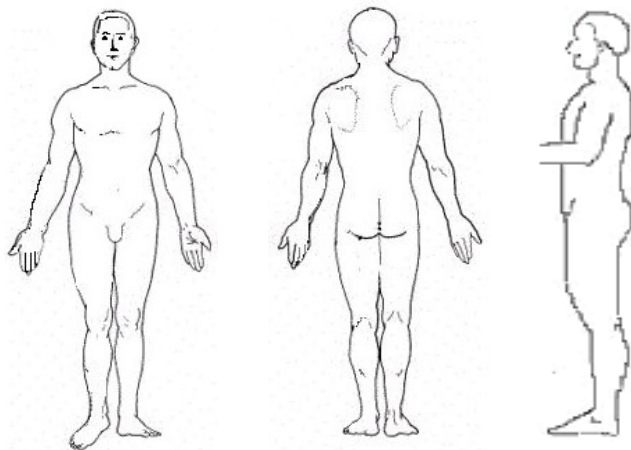
History and Characteristics of Chief Complaint:

If you are currently experiencing any pain, numbness, or physical discomfort, please indicate location on the diagrams to the right.

Please note below any treatments you have sought for this condition:

What makes this condition feel better?

Worse?



Health History: Please check conditions you currently have (✓) or have had in the past (✗):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Impotence | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fatigue Problem | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Stomach Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Problem | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Auto Immune Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Goiter | <input type="checkbox"/> Menstrual Disorder | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraine / Headaches | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | |
| | | <input type="checkbox"/> Polio | |

Symptoms: Using a scale of 1, 2, or 3, please note below any symptoms you have had in the past year. A "1" would indicate a mild occurrence, a "2" would indicate increased severity, and a "3" would be the most severe.

General:

- Fatigue
- Insomnia
- Disturbed sleep
- Frequent dreams
- Excessive sleep
- Dislike of cold
- Dislike of heat
- Weight loss
- Weight gain
- High fever
- Chills
- Hot flashes
- Night sweats
- Unusual daytime sweat
- Lack of sweat when hot
- Extreme thirst
- Thirst with no desire to drink
- Edema or swelling

Skin:

- Rashes
- Hives
- Dry skin
- Oily skin
- Acne
- Easily bruised
- Skin feels tight or cracked
- Dry or brittle nails
- White spots on nails

Head & Neck:

- Headaches
- Muzzy or heavy feeling in head
- Dizziness
- Jaw pain

Eyes & Ears:

- Decreased vision
- Blurred vision
- Visual spots
- Night blindness
- Eye pain / swelling
- Red itchy eyes

- Ringing in the ears
- Decreased hearing
- Ear pain
- Ear discharge

Nose, Throat, & Mouth:

- Nose bleeds
- Excessive nasal discharge
- Frequent sneezing
- Change in sense of smell
- Sore throat
- Hoarse voice
- Difficulty swallowing
- Tight feeling in throat
- Toothache
- Bleeding gums
- Mouth or tongue ulcers
- Dryness or cracks around nostrils, lips or mouth

Muscles & Joints:

- Stiff neck
- Shoulder / arm / hand pain
- Hip / leg / pain
- Low back pain
- Knee problems
- Fullness or dullness below ribs
- Muscle cramps or twitches
- Stiffness when bending or standing up
- Aching in bones after prolonged standing or overwork
- Heavy limbs
- Swollen joints

Nervous system:

- Fainting
- Paralysis
- Tremors
- Poor balance
- Seizures

- Numbness or tingling

Heart, Lungs & Chest:

- Palpitations
- Chest pain or tightness
- Rapid heart rate
- Irregular heart beat
- Swelling of ankles
- Varicose veins
- Cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Asthma / wheezing
- Frequent colds
- Nasal polyps
- Sinus congestion

Mental / Emotional:

- Difficulty concentrating
- Poor memory
- Excessive worry
- Anxious
- Depression
- Easily Irritated
- Frustration or anger
- Fearfulness
- Stress
- Easy or uncontrolled excitability
- Nervous giggling or talkativeness

Digestive:

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Loose Stools
- Bloody / black stools
- Stomach pain
- Abdominal pain
- Poor appetite
- Excessive hunger
- Tired after eating
- Abdominal bloating/ gas

- Belching
- Indigestion
- Acid Reflux
- Hemorrhoids

Urinary / General:

- Painful urination
- Difficult urination
- Frequent daytime urination
- Frequent nighttime urination
- Incontinence
- Cloudy urine
- Bloody urine
- Genital pain, dryness or itch
- Genital discharge or lesions
- Low libido
- Excessive libido

Male:

- Impotence
- Weak urinary stream
- Prostate hypertrophy
- Premature ejaculation
- Seminal emissions

Female:

- Irregular periods
- Painful periods
- Bleeding between periods
- Passing of clots
- Scanty periods
- Early periods
- No periods
- Pre menstrual grouchiness or moodiness
- Menopausal symptoms
- Breast pain or discharge
- Vaginal discharge

Please list any major **Surgeries** or **Traumas**:

Please list any **Medications** or **Supplements** you are currently taking, including dosages:

Please list any **Allergies** and the type of reaction involved:

Please indicate which substances you consume and indicate the amount:

Coffee:

Tobacco:

Alcohol:

Recreational drugs:

Do you **Exercise** regularly? If so please describe activity and amount.

Women Only: Please answer the following questions if applicable to you.

Please note the number of pregnancies you have had, the number of deliveries you have had, plus any relevant information:

Date of last menstrual period:

Date of onset of menopause:

Are you Pregnant?

Are you trying to become Pregnant?

Thank you for taking the time to fill out this Confidential Health History.