Ascent Integrative Health
Traditional Chinese Medicine Intake Form

Welcome to Ascent! We are honoured to partner in your health goals. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly before your first appointment. All information is strictly confidential. Contact Info: T: 403.262.1121 F: 403.262.1371 E: info@ascenthealth.ca

Patient Information

Today's Date: ______________________________ Sex: ☐Male ☐ Female

Full Name: ______________________________________ Preferred Name: ________________________

Address: _____________________________________ Postal Code: ______________ City: ________________ Prov: ______

Home Phone: _______________________ Cell: _______________________ Work: _______________________________

E-mail: ___________________________________ I would like to receive E-mails for appointment reminders, clinic information/ updates, promotional materials etc. *(please note you can opt-out at any time)*

Age: _____ Birthdate: (DD) _____ / (MM) _____ / (YY) _______ Alberta Health Care Number ___________________

Marital Status: __________________ Occupation: ______________________ Employer: _____________________________

Emergency Contact: ________________________ Relationship: _______________ Phone No: _______________________

Is this a WCB injury: ☐ No ☐ Yes Are your injuries related to a Motor Vehicle Accident? ☐ No ☐ Yes

If yes, please ask front desk for the appropriate form.

Medical Information

Family Medical Doctor's Name: _________________________________ Clinic: _________________________________

Date of Last MD Visit: _____________________ Reason: ____

What therapy have you previously received? ☐Chiropractic ☐Massage ☐Acupuncture ☐Physiotherapy

*Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at Ascent to contact your medical doctor? ☐No ☐Yes

Extended Health Benefits

Do you have a private insurance plan? ☐ No ☐ Yes (Self) ☐ Yes (Spouse)

Name of primary policy holder (Spouse/Parent): ____

We offer direct billing for most benefit providers. Name of provider: _________________________________

Policy No: ______________________ Member ID: ________________________

Group No: (*ABC Only): _____________________

How Did You Find Us?

☐Referred by Friend/Family ☐ Referred by Medical Doctor ☐Internet/Website ☐ Walk by

Whom can we thank for this referral? __________________________ ☐ Other: ______________________________

Purpose of Visit?

What is your main health concern or complaint? ____

When did your symptoms first begin? ____

Have you had this before? ☐ No ☐ Yes ; Who did you see for treatment? ______________________________

Is it getting: ☐ Worse ☐ Better ☐ Not Changing

Cancellation Policy & Fee Schedule

I realize that my health insurance may not cover 100% of the recognized fee schedule and that I am responsible for any incurred appointment fees. A **minimum of 24 hours notice** is required for appointment changes and/or cancellations. If less than adequate notice is provided, or if you miss your appointment, Ascent reserves the right to charge your account the full amount of the scheduled appointment.

☐ I agree to the terms ☐ I do not agree to the terms Signature: ___________________________________

Confidentiality & Disclosure of Personal Information

Ascent Integrative Health (ASCENT) understands the importance of protecting personal information. We are committed to the collection, use, and disclosure of this information in a responsible way. Staff members who come into contact with your personal information are trained in the appropriate use and protection of your information.

By signing the consent section of this form, you agree to give consent to the collection use, and disclosure of your personal information for the purposes of:

- Delivering safe & effective patient care
- Enabling us to contact you & process payments
- Communicating with other healthcare providers
- Completing & submitting claims on your behalf to third party payers
- Complying with legal and regulatory requirements
- Filling out relevant requisition forms
- Complying with legal and regulatory requirements

I agree that ASCENT can collect, use, and disclose my personal information as set out above in the clinic's privacy code.

Signature: ________________________________ Printed Name: ____

Informed Consent to Traditional Chinese Medicine Treatment

This consent covers the following TCM treatment modalities:

- Acupuncture (various forms)
- Cupping and Moxibustion
- Tui Na (Chinese medical massage, including acupressure)
- Herbal Therapy
- Medicated Diet and Nutritional Therapy
- Meditation and Breathing Techniques
- Qi Gong

I acknowledge that I have discussed, or have had the opportunity to discuss, the nature and purpose of TCM treatment(s) in general and my treatment(s) in particular, as well as the contents of this consent, with my Registered Acupuncturist and TCM Practitioner.

With regard to acupuncture, I have been advised that all needles are pre-sterilized and are disposed of after each use. I further understand and am informed that, as with all health care, the practices of acupuncture, cupping, moxibustion and tui na pose slight risks, which may include, but are not limited to: temporary bruising, soreness or sensitivity in the area(s) treated, swelling, blistering, bleeding, light-headedness or fainting, nausea, infection and shock.

I also understand that adverse reactions or interactions between recommended herbs, herbal formulas or foods with prescribed medications, supplements or natural health products, though rare, may occasionally occur.

I hereby consent to traditional Chinese medical diagnosis and treatment as described to me by my Registered Acupuncturist and TCM Practitioner. I intend this consent to apply to all my present and future TCM care.

I have read the following and understand that:

- I am responsible for my own health.
- It is my responsibility to inform the Registered Acupuncturist/TCM Practitioner of any medical conditions or allergies that I am aware of and any medications/supplements/herbs that I am currently taking.
- It is my responsibility to inform the Registered Acupuncturist/TCM Practitioner if I am pregnant, may be pregnant or am breast feeding.
- While changes in habits are not a pre-requisite for treatment, failure to follow the recommended dietary and/or lifestyle programs could undermine expected results. I understand that it takes time to feel better when using TCM. I accept that positive changes will occur more rapidly with increased compliance.
- It is my responsibility to clarify treatment issues with my Registered Acupuncturist/TCM Practitioner.
- I am free to discontinue treatment at any time.
- I accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered.

Canceling or rescheduling appointments must be done 24 hours in advance and that I may be charged for missed appointments.

***The signature below implies consent to TCM treatments. Please notify the doctor if you have any questions or if you do not consent to any of the above stated information.**

Dated this_______day of_________________, 20__________

Patient Signature: ___________________________ Printed Name: : _____________________________

Witness Signature: __________________________