

INFORMED CLIENT CONSENT FORM

I _____ agree to participate in the health services with the understanding that the counseling and the treatment/care provided, are for my own lifestyle guidance, education and/or relaxation I acknowledge that the service(s) of any one, and/or all of the following: Acupuncture, Reflexology, Ear Candling, Iridology, Emotional Freedom Technique, Muscle testing, Cosmetic Facial Acupuncture, VoiceBio, Ion Cell Cleanse and/or any other modality that I participate in, are not intended for the purpose of diagnosing or treating a specific ailment. I understand that there may be medical conditions that may be adversely affected by the use of the Ion Cell Cleanse, see following paragraph.

I understand that it is not recommended to use the Ion Cell Cleanse if I have any one of the following; open wounds on my feet, type 1 diabetes, currently receive radiation and/or chemotherapy, have a pacemaker/battery operated or electrical implant, organ transplant recipient, organ removed/especially colon, pregnant or breast feeding, heartbeat regulating medication, taking medication the absence of which would mentally or physically incapacitate you, metal implants/knee/hip etc. Though not dangerous, people having a metal joint implant may find exposure to the electromagnetic field generated by the Ion Cell Cleanse to be uncomfortable.

If you choose to do the Ion Cell Cleanse with any of the above mentioned issues then you acknowledge that you have been advised against the treatment but you have chosen to do the treatment of your own free will and do not hold the practitioner liable for any adverse results that may occur.

I acknowledge that should I take the advice/suggestion(s) given by the practitioner, it is my responsibility to check with my own medical doctor before commencing.

With Acupuncture, I understand that there is a possibility of bruising or minor bleeding from the treatment. Cosmetic Acupuncture can not predict the actual outcome or how long the effects will last. I understand that I do not have any of the contraindications for Cosmetic Acupuncture mentioned by the practitioner.

I attest that the information I have provided is true and complete to the best of my knowledge. I also understand that the information I have provided is confidential and will not be released without my consent.

I acknowledge that the practitioner is not a licensed medical doctor or medical practitioner and I therefore take full responsibility and release the practitioner from liability with respect to any advice or treatment/care which I may follow of my own free will.

I acknowledge that by signing this disclaimer once, it will cover all subsequent visits within one calendar year.

Signature _____ Date _____
(Legal Guardian)

Date of Birth _____

Print name _____

Address _____

City _____ Prov. _____ Postal Code _____

Home # _____ Business # _____

E-mail _____ Fax # _____

How did you hear of this therapist _____

HEALTH RECORD -Please print

Date of birth _____
Blood type, if you know it. _____
Reason for appointment _____
How are you feeling? _____
What are your major concerns? _____
If pain, where is it located _____
What are you doing for your health? **Circle what applies:** exercise, yoga, diet, herbs, vitamins, minerals, meditation, relaxation techniques, chiropractor, M.D., medication, _____
Other _____
Are you seeing other therapists? _____
When did you last see this therapist? _____
What were their findings? _____
Are you taking any medication? Yes/no _____ What? _____
Why? _____ How often? _____
Have you ever had any accidents? _____ What? _____
When? _____
Have you ever had surgery? _____ What? _____
When? _____
Have you ever had any serious illness or diseases? _____
What? _____ When? _____
How is your blood pressure? _____
Please rate the following to do with your present condition and lifestyle: 0-5, zero-not a problem, five-most aggravating.
Fatigue ___ overwork ___ stress ___ relationships ___ nerves ___ worries ___ finances ___
home ___ job ___ food ___ drugs ___ alcohol ___ weather ___ allergies ___ chemicals/fumes ___
Do you smoke? _____ How many a day? _____
Do you drink alcohol? _____ How many a day? _____
Do you drink soft drinks? _____ How many a day? _____
Do you drink tea? _____ What kind(s)? _____
Do you drink coffee _____ How many a day? _____ How do you take it? _____
Do you drink milk? _____ How many a day? _____
Do you drink water? _____ How many 8oz. a day _____
Do you eat bread? _____ What? _____
Do you eat fruit? _____ What? _____
Do you eat vegetables? _____ What? _____
Do you eat meat? _____ What? _____
Do you eat junk foods _____ What? _____
Mother's health history _____

Father's health history _____

Brother's/Sister's health history _____

What do you do for fun? _____

Is there anything else about your health you would like to tell me? _____

M & Y Chiropractic Health and Wellness Centre
Confidential Health History Form

OFFICE POLICIES FOR PATIENTS

It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

UPON ARRIVAL

Please remove your shoes and check in at front desk. Fill out any necessary forms and return them to front desk. One of our health team members will escort or direct you to your adjusting or treatment room.

Chiropractic - Once you are in an adjustment room please empty your pockets (keys, wallet etc.) and remove any earrings and long necklaces. **Please lie face down on the table as this will relax your muscles and take the stress of gravity off your spine thus facilitating a more comfortable adjustment.**

Registered Massage Therapy, Naturopathic Medicine and Alternative Therapies - Once in your treatment room your practitioner will discuss treatments for the session. This may include areas to be treated, your position on the table, benefits/risks, today's goals and a verbal consent will be obtained before the treatment commences. If you want to change or refuse any part of the treatment at any time you have the right to do so. Your practitioner will then leave the room so that you may undress if necessary and re-enter the room once you are ready. You are covered with sheets at all times; only the area being worked on will be uncovered.

After the treatment your practitioner will suggest a treatment schedule to best suit your individual situation. They may also recommend after care exercises or stretching to further enhance your treatments. You may be asked to complete some paperwork between your treatments to allow your practitioner to fully understand the nature of your issues. Those who follow these recommendations notice better and longer lasting results.

YOUR SCHEDULE

Your specific course of care has been designed just for you by your Health Care Provider and your appointment time has been set aside specifically for you. The importance of keeping your appointments and being on time is crucial to help make our office as efficient as possible for the benefit of all our patients. If you do need to reschedule an appointment we require a minimum of 24 hours notice. Any missed appointments or cancellations without adequate notice may result in a fee being charged to you. Due to the healing nature of your treatments, we request that any missed or cancelled sessions be made up at the earliest available time, ideally within 24 hours. Please understand that as a patient you are responsible for any and all charges incurred during the course of your treatment at our wellness centre. When seeing multiple health team members we will do our best to align your appointments together because we value your time as well. If requested, a personal appointment calendar can be supplied to you.

REFERRALS

Once you understand the importance and benefits provided by each of our Health Care Providers, we are confident that you will want everyone in your family checked. The nicest compliment you can give our clinic is to refer us to your family and friends. Please free to ask anyone on our health team for any literature you may require.

Welcome to our Health and Wellness Family.

I agree and understand the above policies. Signed _____