Remedial Wellness Centre

AllergyGone: Confidential Case History Form

Date: _____

Name: _____ MALE □ FEMALE □

Date of Birth: _____ (dd/mm/yyyy)

Address: _____ City_____ Prov: _____

Postal Code: _____ Home Phone: _____ Work Phone:_____

Email:_____ Occupation: _____

Emergency Contact: _____ Emergency Contact Phone:_____

Medical Doctor:_____ MD Phone:_____

Have you had allergy treatment before?

_____

Whom may we thank for referring you?

_____

Notes for patients receiving treatment. Please inform your practitioner if any of these apply to you:
□ Pregnancy or possibility of pregnancy
□ Date of LAST DAY of LAST menstrual cycle _____(dd/mm/yyyy)
□ Immune compromised conditions or systemic medical diseases (i.e. autoimmune diseases, SLE [lupus], rheumatoid arthritis, severe burns, multiple sclerosis, scleroderma, dermatomyositis, Crohn's disease, etc)
□ Radiation treatment or chemotherapy
□ High steroid doses (cortisone, prednisone)

Do you have any medical conditions not listed above? *If yes, please explain:*
_____
_____
_____

Current Condition and Health History

For what allergy are you seeking care today?
_____
_____

How long have you had the allergy? _____

Allergy history: _____
_____

Have you seen or are you seeing any other health care professional(s) for this condition? *If so, whom?* _____

Prescription or over-the-counter drugs and supplements (please list name, frequency and condition being treated:

Name	Dosage/Day	Condition Being Treated

Surgeries (type and date): _____
_____
_____

Informed Consent to AllergyGone Treatment

I do hereby give my voluntary informed consent for the administration to me of an AllergyGone treatment and other relevant homeopathic therapies. I declare that I have received information about the nature of the treatment, benefits, risks, and potential discomfort. I do not expect the therapist to be able to anticipate and explain all possible risks and complications. I wish to rely on the practitioner to exercise judgment during the course of the procedure which (s)he feels at the time, based upon the facts then known, is in my best interest. I understand that no guarantee has been made for expected treatment results and that not all allergy therapy sessions are resolved in one visit, if at all. The therapist has responded to all my requests for further information about the treatment proposed.

I have read the above consent and have been given the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present and for any future conditions for which I may seek treatment. I understand that my consent is required prior to releasing my records to another practitioner, insurance company or any other agency or person except where required by law.

In respect to receiving assessment and treatment with Louise Grenier, BScN, Advanced Linguistic Programming and Homeopathic Practitioner, at Remedial Wellness Centre in Edmonton, Alberta:

I declare that I am at least 18 years old and herby give consent to treatment.

_____

Signature of Client Date

For patients under 18 years, I declare that I am the patient's parent or legal guardian and hereby give consent to treatment.

_____

Signature of Parent/Guardian Date

AllergyGone Cancellation Policy

Please be advised that there is a 12 hour missed/cancelled appointment policy in effect for AllergyGone Treatment at Remedial Wellness Centre. Late cancellations (within 12 hours) and missed appointments will be charged 50% of the appointment fee. The same applies if the therapist misses an appointment with a client; (the client's next appointment will be 50% of the full fee).

In order to be consistent with all clients, cancellation fees will only be waived in the event of a medical emergency requiring urgent professional treatment, a major event in the family or natural disaster.

We are committed to providing you with the highest quality service possible and we ask that you understand that it is nearly impossible to fill appointments spots on the day they are cancelled. Thank you for your understanding and we look forward to helping you on your way to better health.

I hereby confirm that I have read, understand and agree to the above terms.

_____

Signature of Client Date