evolve*

CHIROPRACTIC & WELLNESS CENTRE

Evolve 5th Avenue
Suite 116, Calgary Place
414 - 3rd Street SW
Calgary, AB, T2P 1R2
E: 5thAve@evolvechiro.ca
T: 403.474.7792
F: 403.719.0356

Evolve 8th Avenue
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T: 403.474.7792
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Chiropractic Intake Form

*denotes R Macdonald Professional Corporation

Last Name ______ First Name ______ How did you hear about us? ______

Address ______ City ______ Postal Code ______

Cell Phone ______ Work Phone ______ Emergency Contact ______

Occupation ______ Email (I agree to receive appointment reminders and clinic updates) ______

Birthdate (dd/mm/yr) ______ Gender ______ Marital Status ______ Alberta Health Care Number ______

For your convenience, we can keep a credit card on file:

Number:_________-________-________-_________ Expiry:____/_____ CCV: _______

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name ______ Group ID/Policy Number ______ Member Number ______

Relationship to Cardholder (self, spouse, child) ______ Name of Cardholder ______

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

Reason for appointment? ______

When did your condition begin? ______

Have you had X-rays, MRI or other tests? ______

Have you ever tested postive for any blood-borne diseases? (HIV, AIDS, Hepatitis C, etc) ____________ Yes No

Are you immunocompromised? Yes No Are you taking blood thinners? Yes No

Is this condition related to: Work? Yes No Has your employer been notified? Yes No

Motor vehicle accident? Yes No Date of injury: ______

Can you perform your daily home activities? Yes Yes, only with help Not at all

Can you perform your daily work activities? All Only some Not at all

Describe your stress level: None Mild Moderate High

Are you, or do plan to become pregnant? Yes No Unknown

Please list any previous surgeries,

Illnesses, injuries (motor vehicle accident):______

Have you had previous chiropractic care? Yes No Doctor:______Date:______

Family doctor name: ______

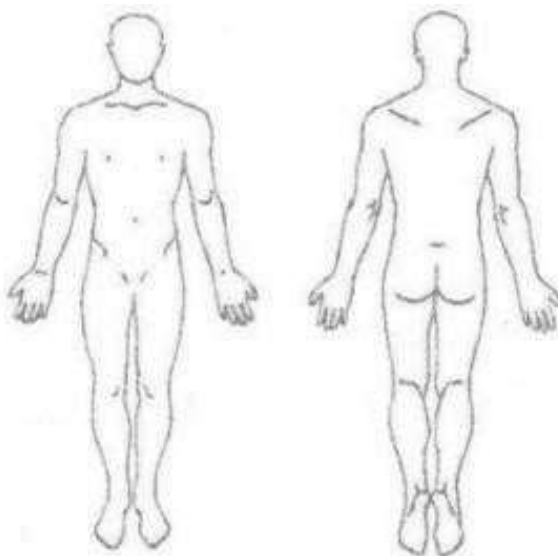
List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) ______

HEALTH HISTORY QUESTIONNAIRE

Have you ever been diagnosed or told you have any of the following?
Please check the correct response:

1.	High blood pressure	Yes	No
2.	Hardening of the arteries (arteriosclerosis)	Yes	No
3.	Diabetes	Yes	No
4.	Tuberculosis	Yes	No
5.	Cancer, where? ________________________________	Yes	No
6.	Heart or blood diseases	Yes	No
7.	Bone spurs on the neck bones (cervical sprain)	Yes	No
8.	Osteoporosis	Yes	No
9.	Whiplash injury (flexion-extension injury, cervical sprain)	Yes	No
10.	Have you ever suffered a stroke?	Yes	No
11.	Were you ever a smoker? From__________To__________	Yes	No
12.	Do you take any medication on a regular basis?	Yes	No
13.	Visual disturbances (blurring, loss, double)	Yes	No
14.	Hearing disturbances (loss, ringing, other noise)	Yes	No
15.	Slurred speech or other speech problems	Yes	No
16.	Difficulty swallowing	Yes	No
17.	Dizziness	Yes	No
18.	Loss of consciousness, even momentary blackouts	Yes	No
19.	Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body	Yes	No
20.	Sudden collapse without loss of consciousness	Yes	No

Indicate the location of your pain by shading the appropriate area:



Indicate the severity of the pain by selecting a number:

	0	1	2	3	4	5	6	7	8	9	10	
No Pain												**Extreme Pain**

Informed Consent for Chiropractic and Acupuncture Care

Dr. Ryan MacDonald and Dr. Ryan Boyd 403.474.7792
Chiropractors
www.evolvechiro.ca

Chiropractic

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits:

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks:

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **The temporary worsening of symptoms**-- Usually, any increase in pre-existing symptoms of pain or stiffness will only last a few hours to a few days.
- **Skin irritation or burn**-- Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or Strain**-- Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture**-- While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc**-- Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke**-- Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.
  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives:

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns:

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

____
Patient Signature (or Legal Guardian)

Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above named doctor or another duly authorized doctor in the clinic.
I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of the treatment for my present and future conditions for which I seek treatment.

____
INITIALS

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

____
INITIALS

Consent to Release Information

I give Evolve Chiropractic & Wellness Center my consent to release/obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

- Physician(s)
- Employer
- Insurer
- Other

____
INITIALS

Credit Card Holder Authorization

I, the previously-named authorized credit card user, give Evolve Chiropractic and Wellness Center express authorization to charge my credit card for the purposes of 1) Payment for services rendered by any practitioner at Evolve Chiropractic and Wellness Center. 2) Payment for goods purchased from any practitioner at Evolve Chiropractic and Wellness Center. 3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges as well as any and all collection and legal fees. This credit card is authorized for only the charges noted above.

____
INITIALS

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL ACCOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Dated this______day of________________, 20________.

____
Name (Please Print)

______________________________ ______________________________
Patient Signature (or Legal Guardian) Chiropractor Signature