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evolve
CHIROPRACTIC & WELLNESS CENTRE

Manual Osteopathic Therapy 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 (direct billing is currently unavailable for Osteopathic Services)**

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 osteopathic care? Yes No Doctor: ____ Date: ____

Family doctor name: ____

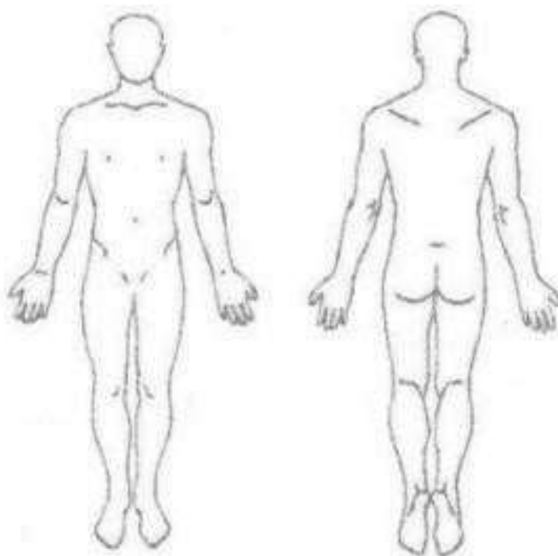
List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) ____

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**

CANADIAN FEDERATION OF OSTEOPATHS

Informed Consent for Osteopathic Manual Therapy

Evolve Chiropractic and Wellness Centre
www.evolvechiro.ca
403-474-7792

Osteopathic Therapy

I understand that the Osteopathic Manual Therapist is providing osteopathic manual therapy services within their scope of practice.

I hereby consent to my Osteopathic Manual Therapist to treat me with Osteopathic manual therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Manual Therapist.

I acknowledge that the Osteopathic Manual Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Osteopathic Manual Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Therapist and have disclosed to the Osteopathic Manual Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I hereby acknowledge that I have discussed with the osteopathic therapist 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 o treatment as proposed to me. I understand that at any time I may withdraw my consent and treatment will be stopped.

____
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.

____
INITIALS

Dated this______day of________________, 20________.

____
Name (Please Print)

______________________________ ______________________________
Patient Signature (or Legal Guardian) Osteopathic Therapist Signature