evolve*
CHIROPRACTIC & WELLNESS CENTRE

☐ **Evolve 5th Avenue**

Calgary Place
Suite 116, 414 - 3rd Street SW
Calgary, AB, T2P 1R2

E: 5thAve@evolvechiro.ca
T: 403.474.7792
F: 403.719.0356

■ **Evolve 8th Avenue**

Watermark Tower
Suite 110, 530 - 8th Avenue SW
Calgary, AB T2P 3S8

E: 8thAve@evolvechiro.ca
T: 403.474.7792
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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 for osteopathy is currently available through Greenshield and Alberta Blue Cross only.

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: _____

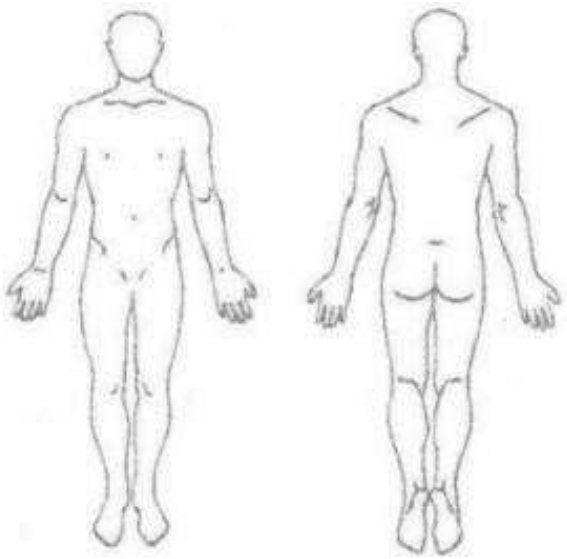
List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

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