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evolve

CHIROPRACTIC & WELLNESS CENTRE

MOVE. THRIVE. EVOLVE.

* denotes R Macdonald Professional Corporation

Last Name _____ First Name _____ Who can we thank for the referral? _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Emergency Contact _____

Occupation _____ Email (For appointment reminders, Invoices and clinic updates ONLY) ☐ I agree

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

For your convenience and to expedite your check out, we are happy to upload your credit card information to your secure file: *You can remove this information at anytime

Number: _____ - _____ - _____ - _____ Expiry: ____ / ____ CCV: _____

For more information on our policy and security procedures, please don't hesitate to ask our front desk!

EXTENDED HEALTHCARE COVERAGE

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

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

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
F: 587.356.1188

Main reason for appointment? _____

How is your overall health? _____

Have you had any surgeries? Date and nature: _____

Do you have any pins, wires, artificial joints/limbs? Where? _____

Have you had previous massage therapy care? ◯ Yes ◯ No

Do you currently see other practitioners? (i.e. chiro): ◯ Yes ◯ No Who? _____

Please check any health conditions that apply to you:

- ☐ Heart attack Stroke
- ☐ High blood pressure
- ☐ Low circulation
- ☐ Tachycardia
- ☐ Bradycardia
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma Emphysema
- ☐ Loss of sensation
- ☐ Numbness Tingling
- ☐ Epilespsy Fainting

Digestive

- ☐ Constipation
- ☐ Chron's Disease
- ☐ Colitis
- ☐ IBS

Head and Neck

- ☐ Migraines
- ☐ Headaches
- ☐ Vision loss
- ☐ Ear aches
- ☐ Hearing loss

Muscle Stiffness

- ☐ Neck
- ☐ Shoulders
- ☐ Back
- ☐ Upper arms
- ☐ Lower arms
- ☐ Upper legs
- ☐ Lower legs
- ☐ Hips
- ☐ Hands
- ☐ Feet

Women

- ☐ Painful menstruation
- ☐ Miscarriage
  - # of pregnancies
  - # of children
- ☐ Other _____

Other

- ☐ Arthritis
- ☐ Cancer type _____
- ☐ Diabetes type _____
- ☐ HIV
- ☐ TB
- ☐ Hepatitis

Are there any other conditions not listed above?

I understand that the massage I receive is provided for the purpose of muscle tension, stress reduction, relief, and/or relaxation. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Although minimal, I am aware of the possible side effects that massage therapy may produce including, but not limited to bruising, muscle soreness, headaches, tenderness, and fatigue.

I acknowledge I have read this consent and I have discussed or have had the opportunity to discuss the above with my massage therapist. I consent to all my present and future massages with Evolve Chiropractic and Wellness Centre.

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 physiotherapist 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 physiotherapy treatment as proposed to me.

Name (Please Print) _____ Date _____

Patient Signature (or Legal Guardian) _____ RMT Signature _____