*

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

HEALTH INFORMATION

Health Priorities/ Chief Concerns:

List your main health concerns in order of importance:

1. _____

_____

2. _____

_____

3. _____

_____

Describe your overall health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

LIFESTYLE

Living environment: ☐ Dry ☐ Damp

Favorite food and drink type: ☐ Sour ☐ Sweet ☐ Salty ☐ Greasy ☐ Spicy

Do you use any of the following: ☐ Cigarettes ☐ Alcohol ☐ Recreational Drugs

Glasses of water per day? _____

Cups/ glasses per day? Coffee ____ Black tea ____ Herbal tea ___ Pop ____ Other _____

Do you exercise? ☐ Yes ☐ No What type, how often? _____

Have you recently gained or lost weight? ☐ Yes ☐ No Weight gained/lost_____

Rate your stress level: (low) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high)

Are you frequently in a state of: ☐ Fear ☐ Worry ☐ Anger ☐ Sadness ☐ Anxiety

Which factors most contribute to your stress? ☐ Health ☐ Work ☐ Money ☐ Family ☐ Marriage ☐ Relationship ☐ Other

_____

Is there anything that you feel is important that has not been covered?

_____

_____

MEDICAL HISTORY

Please indicate any serious illnesses, conditions, or reasons for hospitalization.

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement/Brand	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please indicate any allergies and/or food sensitivities.

Allergy/Food Sensitivity	Symptoms

FAMILY HISTORY

Please indicate whether you or your immediate family members have or had the following:

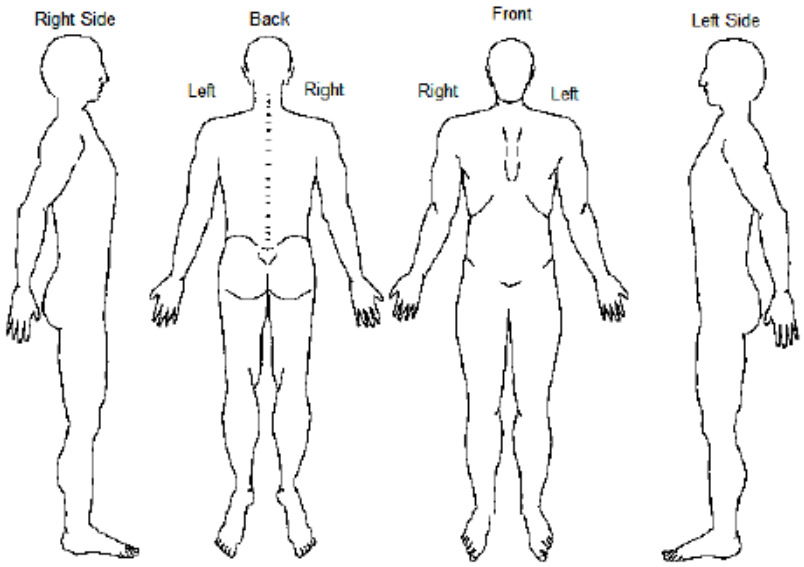
Condition	Who?	Condition	Who?	Condition	Who?
Alchoholism		Cancer Type:		Depression	
Allergies				Osteoporosis	
Alzeimers		Drug Addiction		Parkinsons	
Arthritis Type:		Diabetes Type:		Seizure/Epilepsy	
				Stroke/Aneurysm	
Asthma		Eczema/Psoriasis		Thyroid Condition Type:	
Autoimmune Disease Type:		Heart Disease			
		Kidney Disease		Tuberculosis	
HIV/AIDS		Liver Disease		Other	

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 ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your Doctor of Chinese Medicine and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits
Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks
The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the Doctor of Chinese Medicine if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy
The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your Doctor of Chinese Medicine if you are pregnant or actively trying to be.

Alternatives
Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the Doctor of Chinese Medicine'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 Doctor of Chinese Medicine immediately of any change in your condition.**

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE DOCTOR OF CHINESE MEDICINE

I hereby acknowledge that I have read this form and discussed with the Doctor of Chinese Medicine 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 acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Doctor of Chinese Medicine		Date

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)
- Insurer
- Employer
- 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)