



MOVE. THRIVE. EVOLVE.

_____	_____	_____	
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

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

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 positive 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 you plan to become pregnant? Yes No Unknown

Please list any previous surgeries, _____

SYSTEM REVIEW

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

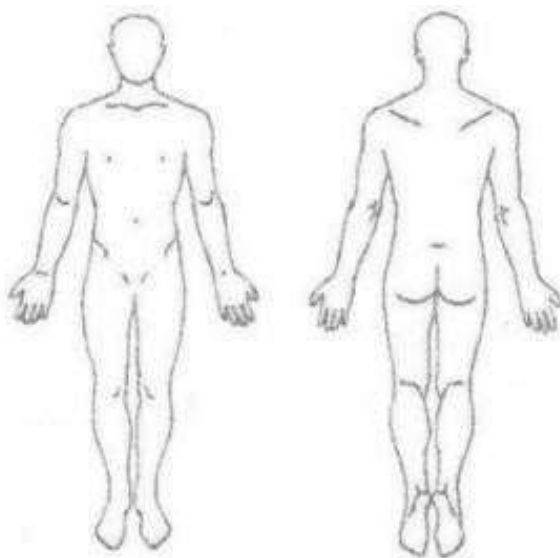
<u>GENERAL SYMPTOMS</u>	<u>RESPIRATORY</u>	<u>GENITOURINARY</u>	<u>NEUROLOGICAL</u>	<u>CARDIOVASCULAR</u>
Fever	Chronic cough	Frequent urination	Visual disturbance	Rapid beating heart
Sweats	Spitting up phlegm	Painful urination	Dizziness	Slow beating heart
Fainting	Spitting up blood	Blood in urine	Fainting	High blood pressure
Sleep disturbance	Chest pain	Pus in urine	Convulsions Headache	Low blood pressure
Fatigue	Wheezing	Kidney Infection	Numbness	Pain over heart
Nervousness	Difficulty breathing	Prostate trouble	Neuralgia (nerve pain)	Hardening of arteries
Weight loss	Asthma	Uncontrollable urine flow	Poor coordination	Swollen ankles
Weight gain			Weakness	Poor circulation
				Palpitations
				Cold hands or feet
				Varicose veins
<u>GASTROINTESTINAL</u>	<u>EYES, EARS, NOSE, THROAT</u>	<u>MUSCLE & JOINT</u>	<u>FOR WOMEN ONLY</u>	
Poor appetite	Eye Pain	Neck pain	Painful menstration	
Difficult digestion	Double Vision	Low back pain	Hot flashes	
Heartburn	Ringing in ears	Arm pain	Irregular cycle	
Ulcers	Deafness	Shoulder pain	Cramps or back pain Vaginal discharge	
Nausea	Nosebleeds	Leg pain	Nipple discharge	
Vomiting	Trouble swallowing	Knee pain	Lumps in breast Menopausal symptoms Birth control pills	
Constipation	Hoarseness Sinus infection Nasal drainage	Foot pain	Miscarriages	
Diarrhea		Pain/numbness down arms or legs	Complications with pregnancy	
Blood in Stool		Pain between shoulders swollen joints Spinal curvature	Pregnant? Y / N Week?	
Gallbladder/ jaundice Colitis	Enlarged glands	Arthritis	Other:	
		Fractures		

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 CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT

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:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only 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.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

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.

Name (Please Print)

Signature of patient (or legal guardian)

Date: _____ 20____

Signature of Chiropractor

Date: _____ 20____



CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

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 chiropractor 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 chiropractor 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 chiropractor 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 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.**

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have read this form and 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 acupuncture treatment as proposed to me.

Name (Please Print)

Signature of Patient (or legal guardian)

Date

Signature of Chiropractor

Date

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.

Name (Please Print)

Date

Patient Signature (or Legal Guardian)