



\*

## 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

Please provide the details of your health care provider:

Doctor's Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Address: \_\_\_\_\_

What is your main reason for seeking a Natural Nutrition Practitioner :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What outcome are you hoping to achieve? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

---

### Health Profile

Please provide your current: (if unknown please leave blank)

Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Waist circumference: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Date last checked: \_\_\_\_\_

What is your desired weight: \_\_\_\_\_

If you are over 40, have you received a Medical Exam?      Yes      No

If yes, please provide details of results: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please list your main health concerns in order of priority including how long you have been experiencing the problem and any medication you are or have taken to treat it.**

Health Concern (ie. Weight management, type 2 diabetes, high cholesterol, etc.)	Duration	Management so far (Doctor, Exercise, dieting, operation, etc.)

### Lifestyle

Please describe your physical activity using the table:

Activity	Type/intensity (ie. Low, moderate, high)	# days per week	Duration (minutes)
Stretching/Yoga			
Cardio (walking, jogging, running, swimming, biking, hiking etc.)			
Strength training (weight lifting, Pilates, etc.)			
Sports or leisure			
Other (please specify)			

How many hours of sleep do you get a night? \_\_\_\_\_

On a scale of 1 – 10 (10 being the most stressful), how stressful do you find daily life? \_\_\_\_\_

What are your methods of coping with stress? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke?    Yes    No    If yes, how often? \_\_\_\_\_

Do you drink alcohol?    Yes    No    If yes, how often? \_\_\_\_\_

---

### Digestion

Do you associate any foods with digestive symptoms?    Yes    No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_

Do you regularly experience:

Heartburn	Often	Sometimes	Never
Constipation	Often	Sometimes	Never
Diarrhea	Often	Sometimes	Never
Bloating	Often	Sometimes	Never
Gas	Often	Sometimes	Never
Nausea	Often	Sometimes	Never
Stomach pain	Often	Sometimes	Never

## Diet History

Do you have any dietary restrictions or limitations for cultural or religious beliefs?      Yes      No

If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any known allergies and/or intolerances: \_\_\_\_\_

\_\_\_\_\_

Who prepares most of your meals? \_\_\_\_\_

Please specify approximate percentage of your meals which are:

Home cooked: \_\_\_\_\_      Convenience: \_\_\_\_\_      Take-away: \_\_\_\_\_

Please Check the following diet/nutritional program(s) that apply:

Low fat	Low carb	High Protein	Ketogenic
Gluten Free	Vegetarian	Weight loss	Low sodium
Diary Free	Vegan	Diabetic	Other: _____

How many meals/snacks do you eat a day? \_\_\_\_\_

Do you regularly eat:

Breakfast      Lunch      Dinner

What are your favorite foods: \_\_\_\_\_

\_\_\_\_\_

Which foods do you dislike? \_\_\_\_\_

\_\_\_\_\_

Which foods do you crave? \_\_\_\_\_

\_\_\_\_\_

Which foods do you have hard to give up? \_\_\_\_\_

\_\_\_\_\_

Please indicate the amount, type and frequency of beverages you consume:

Beverage type (please check which type)	Amount of Sugar (if added)	Daily amount (ex. 2x 8oz cups)	Weekly amount (ex. 6x 8oz cups)
Water			
Coffee:   Decaf Regular Latte			
Tea: (specify which type)			
Juice:    Natural Fruit drinks			
Fizzy drinks:  Regular Diet			
Milk:       Whole Semi Skim			
Milk Substitutue: (specify which type)			
Alcohol:   Wine Beer Spirits Other			

## Medical Symptoms Checker

Please check any of the following symptoms you may be experiencing (in the last 30 days).

### Head

Headaches  
Migraine  
Dizziness  
Insomnia  
Faintness

### Mouth

Tooth decay  
Mouth ulcers  
Sore throat  
Chronic cough  
Gingivitis

### Eyes

Watery or itchy eyes  
Swollen or puffy eyes  
Blurred vision  
Dry Eyes

### Nose

Stuffy nose  
Sinus problems  
Hay fever  
Post nasal drip  
Rhinitis

### Joints/Muscles

Painful  
Inflamed  
Swollen  
Stiff  
Reduced Mobility  
Arthritis

### Mood

Mood swings  
Anxiety  
Depression  
Anger  
Irritability  
Tear  
Jittery  
Tired

### Mind

Poor memory  
Poor concentration  
Easily frustrated  
Difficulty making decisions  
Loss of interest  
No motivation  
Can't switch off

### Skin

Acne  
Eczema  
Rash  
Dry skin  
Excessive sweating  
Hot flashes  
Oily skin  
Hair loss

### Digestive Tract

Bloating  
Cramping  
Belching/passing gas  
IBS  
Coeliac  
Constipation  
Heartburn  
Stomach Pain

### Weight

Binge eating/drinking  
Cravings  
Excessive weight  
Water retention  
Underweight  
Compulsive eating

### Ears

Earaches  
Ear infection  
Ringing in ears

### Chest

Heart palpitations  
Rapid Heartbeat  
Chest pain  
Short of breath  
Difficulty breathing  
Frequent chest infections  
Asthma

## Medication History

Please specify any medications that you have taken over a length of time or have taken repeatedly (this includes prescription or over the counter).

Medication	Year Started	Reason for Taking	Duration and Dosage

## Vitamins and Supplements

Please list any nutritional supplements and/or herbal supplements you are currently taking or have taken in the past.

Supplement (name and brand if possible)	Dose	Duration	Reason for Taking



## Family History

Please list any illnesses or conditions that your family members have experienced

Mother		Maternal Grandmother	
		Maternal Grandfather	
Father		Paternal Grandmother	
		Paternal Grandfather	
Sister(s)		Brother(s)	
Children			

Please indicate on a scale of 1 - 10, how motivated you are to change your diet and lifestyle

0      1      2      3      4      5      6      7      8      9      10  
**Not at all ready** **Actively Changing**

Please indicate on a scale of 1 - 10 how important it is for you that you change.

0      1      2      3      4      5      6      7      8      9      10  
**Not important** **Very Important**

What are your motivations for changing your behavior?

---



---



---



---

I have disclosed all the information relevant to this consultation which applies to my health and lifestyle. I consent for the information provided to be used by my Natural Clinical Nutrition Practitioner.

Signature: \_\_\_\_\_

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 practitioner 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.

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE NATURAL NUTRITION  
CLINICAL PRACTITIONER**

**I hereby acknowledge that I have discussed with the practitioner 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 treatment as proposed to me.**

\_\_\_\_\_  
**Name (Please Print)**

**Date:** \_\_\_\_\_ **20**\_\_\_\_\_

\_\_\_\_\_  
**Signature of patient (or legal guardian)**

**Date:** \_\_\_\_\_ **20**\_\_\_\_\_

\_\_\_\_\_  
**Signature of Practitioner**



## Client Statement

I understand and acknowledge that Melissa Cronshaw is dedicated to protecting and advancing the general well-being of clients in a natural way and is not operating as a centre for the treatment of disease or illness.

The services performed by Melissa Cronshaw are at all times restricted to consultation about health matters intended for general well-being and do not involve the diagnosing, prognosticating, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine in this province. I understand that he/she is not a medical practitioner, naturopath, or dietician.

I am aware that all activities, programs, and services offered are educational, recreational, or self-directed in nature. I assume full responsibility during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental, or emotional) and the awareness, care, and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, program or service of Melissa Cronshaw brings with it the assumption by me of those risks or results stemming from these choices and the fitness, health, awareness, care and skill that I possess and use. I understand that I am free to withdraw from, reduce or modify my involvement in any program/activity and I realize that I should do so upon recognition of any signs of transient light-headedness, fainting, chest discomfort, cramps, nausea, allergic reaction etc.

I also acknowledge that I have inquired about the nature of any activity, program, or service that I am not completely familiar with, and I have been informed of any inherent risks.

I understand that all the information which I provide is purely for the purpose of assessment and that no information will be disclosed to others or used in any other manner without my written permission.

This statement is being signed voluntarily.

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Signature: \_\_\_\_\_

### 3 Day Food Diary

Please record your typical food and drink intake for 3 days using the following table. Please provide brands, portion sizes, quantities, and times of meals whenever possible.

	Weekday 1	Weekday 2	Weekend Day
Breakfast (Ex. 2 small eggs fried in olive oil, 1 piece of whole wheat toast with 1 tsp butter. 250 ml coffee with 2 tsp full fat milk.			
Lunch			
Dinner			
Snacks			