



**MOVE. THRIVE. EVOLVE.**

\*denotes R Macdonald Professional Corporation

<hr/>		<hr/>		<hr/>	
Last Name		First Name		Who can we thank for the referral?	
<hr/>		<hr/>		<hr/>	
Address		City		Postal Code	
<hr/>		<hr/>		<hr/>	
Cell Phone		Work Phone		Emergency Contact	
<hr/>		<hr/>		<hr/>	
Occupation		Email (For appointment reminders, Invoices and clinic updates ONLY)			I agree
<hr/>		<hr/>			<hr/>
Birthdate (dd/mm/yr)		Gender	Marital Status	Alberta Health Care Number	
<hr/>		<hr/>	<hr/>	<hr/>	

**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

<hr/>		<hr/>		<hr/>	
Insurance Company Name		Group ID/Policy Number		Member Number	
<hr/>		<hr/>		<hr/>	
<hr/>			<hr/>		
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 plan to become pregnant? Yes No Unknown

Please list any previous surgeries, illnesses, injuries (motor vehicle accident): \_\_\_\_\_

Had previous chiropractic care: Yes No Doctor: \_\_\_\_\_

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

**SYSTEM REVIEW**

Please **check** any conditions that are **presently** causing you a problem or 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

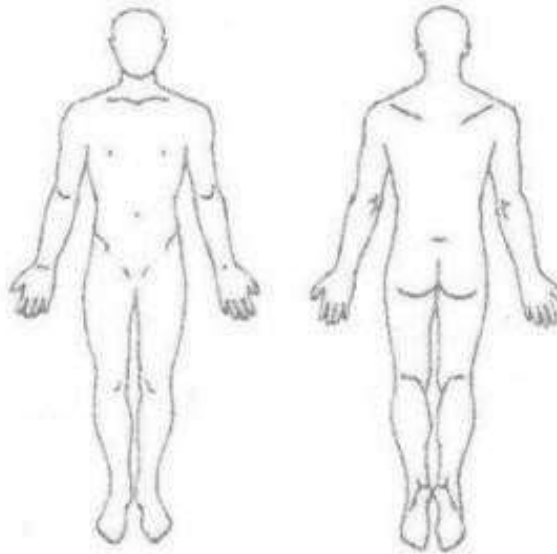
<u>GASTROINTESTINAL</u>	<u>EYES, EARS, NOSE, THROAT</u>	<u>MUSCLE &amp; JOINT</u>	<u>FOR WOMEN ONLY</u>
Poor appetite	Eye Pain	Neck pain	Painful menstruation
Difficult digestion	Double Vision	Low back pain	Hot flashes
Heartburn	Ringing in ears	Arm pain	Irregular cycle
Ulcers	Deafness	Shoulder pain	Cramps or back pain
Nausea	Nosebleeds	Leg pain	Vaginal discharge
Vomiting	Trouble swallowing	Knee pain	Nipple discharge
Constipation	Hoarseness	Foot pain	Lumps in breast
Diarrhea	Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Blood in Stool	Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Gallbladder/jaundice	Enlarged glands	Spinal curvature	Miscarriages
Colitis		Arthritis	Complications with pregnancy
		Fractures	Pregnancy? Yes No
			Week? _____
			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<br>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

**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 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)