*

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

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

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)

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

Hobbies _____

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

_____

_____

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	

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

How many courses of antibiotics have you had in the past 5 years? _____

Were you frequently given antibiotics as a child?_____ If so, for what?_____

Have you had an adverse reactions from any vaccinations? _____

Do you use any of the following?

Type	Check one	How much/How often/Form
Alcohol	☐ Yes ☐ No	
Tobacco	☐ Yes ☐ No	
Caffeine	☐ Yes ☐ No	
Recreational Drugs	☐ Yes ☐ No	
Laxatives	☐ Yes ☐ No	
Antacids	☐ Yes ☐ No	
Diet Pills	☐ Yes ☐ No	
Pain Medication/ Pain Killers	☐ Yes ☐ No	
Birth Control	☐ Yes ☐ No	

Please indicate which of the following screening tests you receive.

Test	Check one	How often/ Most recent date
CBC (complete blood count)	☐ Yes ☐ No ☐ Never	
Breast Exam	☐ Yes ☐ No ☐ Never	
Mammogram	☐ Yes ☐ No ☐ Never	
DEXA Scan	☐ Yes ☐ No ☐ Never	
PAP Test (women)	☐ Yes ☐ No ☐ Never	
Digital Rectal Exam (Men)	☐ Yes ☐ No ☐ Never	
Testicular Exam (Men)	☐ Yes ☐ No ☐ Never	
PSA (Men)	☐ Yes ☐ No ☐ Never	
Cholesterol	☐ Yes ☐ No ☐ Never	
Blood Glucose	☐ Yes ☐ No ☐ Never	
Other (x-ray, ultrasound, EEG, ECG, CT scan, MRI, ect.)	☐ Yes ☐ No ☐ Never	

Please check any symptoms that apply to you:

☐ Fatigue	☐ Insomnia	☐ Weight gain	☐ Weight loss
☐ Anemia	☐ Eczema	☐ Acne	☐ Psoriasis
☐ Chronic pain	☐ Asthma	☐ Seasonal allergies	☐ TMJ/jaw pain
☐ Chronic muscle tension	☐ Muscle cramping	☐ Headaches/migraines	☐ Arthritis
☐ High blood pressure	☐ Low blood pressure	☐ Numbness/tingling/weakness	☐ Constipation
☐ Diarrhea	☐ Clotting disorder	☐ Heart palpitations	☐ Abdominal pain
☐ Bloating/gas	☐ Frequent cold/flu	☐ Chronic stress	☐ Anxiety
☐ Depression	☐ Poor memory	☐ Recreational drug or alcohol use	☐ Low libido
☐ Erectile dysfunction	☐ PMS	☐ Irregular menstrual cycle	☐ Other:

Have you ever had IV or injection treatments previously? ◯ Yes ◯ No

Have you had any issues with previous blood draws or injections?

☐ Difficult veins ☐ Needle phobia ☐ Allergy ☐ Inflitraion ☐ Other adverse reaction

Have you had any recent blood work (in the past three months)? ☐ Yes ☐ No

IV/ Injection Consent

I understand that the form of medical care that I will receive is based on naturopathic principles, practices and therapies. These may include, but not be limited to: physical examination, diagnostic procedures, nutritional counseling, botanical medicine, vitamin & mineral supplementation, injection therapies and counseling. As with any therapy, I understand that no treatment is guaranteed to be successful. I also understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or unless required by law. Though naturopathic therapies are proven safe when used correctly, I recognize the potential risks that include, but are not limited to: aggravation of pre-existing symptoms, discomfort, pain, fainting, bruising or bleeding from venipuncture site, infection at the site of needle insertion, inflammation of the vein (phlebitis), mild allergic reactions and in extremely rare instances severe allergic reactions, anaphylaxis, cardiac arrest and death. I have read and understood the above statement, accept the risk and thereby consent to treatment. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without stating. I accept full responsibility for any fees incurred during care and treatment.

IV and injection therapies are most well tolerated when patients come in prepared for their treatment. This means that you must be well hydrated, avoided coffee, have eaten in the last 2-3 hours and are not rushed for time. It often helps to stay warm and/ or exercise before your treatment as well.

I am aware that my preparation is important to the success of my treatment and that I must be hydrated and have had adequate food prior to treatment.

Name: _____ **Signature: _____**

(please print) **(patient or legal guardian)**

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 doctor of naturopathic 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 naturopathy treatment as proposed to me.

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

I hereby acknowledge that I have discussed with the Doctor of naturopathic 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 naturopathy treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Doctor of Naturopathic Medicine

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CHIROPRACTIC & WELLNESS CENTRE

Dr. Jatish Kaler, ND
Doctor of Naturopathic Medicine
Suite 116, 414 – 3 Street
SW Calgary, AB T2P 1R2
T: 403.474.7792

Declaration and Consent to Treatment

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding

There are some health risks associated with treatment by Naturopathic Medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture
- Accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, and disc injuries from spinal manipulation.
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the ND to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of my treatment which she feels is in my best interest based on the facts which are known**.**

I also understand that pharmaceutical grade supplements and herbal medicines prescribed and sold by my naturopathic doctor may be a part of my treatment protocol. This is to ensure that the appropriate dose and quality of medicine is administered and immediately available, in order to provide the most effective treatment possible. I also understand that there may be an additional cost for certain diagnostic procedures.

With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend for this consent to cover the course of my treatment. I am free to withdraw my consent and discontinue treatment at any time. I

Dated this_____ day of_____, 20_____.

Name: _____ **Signature: _____**

(please print) **(patient or legal guardian)**

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CHIROPRACTIC & WELLNESS CENTRE

Dr. Jatish Kaler, ND
Doctor of Naturopathic Medicine
Suite 116, 414 – 3 Street
SW Calgary, AB T2P 1R2
T: 403.474.7792

Consent for Collection, Use, and Disclosure of Personal Information

Your Naturopathic Doctor understands the importance of protecting your personal information.

To help you understand how she does that, here is an outline of how your Naturopathic Doctor may use and disclose this information:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To inform you of change of location/moving
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other health-care providers i.e. MDs, NDs, Osteopaths
- To allow your Naturopathic Doctor to efficiently follow-up for treatment, care and billing
- To invoice for goods and services
- To process payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- To be used for research purposes.

Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how my Naturopathic Doctor will use my personal information, and the steps that she is taking to protect my information.

I agree that my Naturopathic Doctor can collect, use and disclose personal information about me as set out above in the information about my Naturopathic Doctor's privacy policies.

Dated this_____ day of_____, 20_____.

Name: _____ **Signature: _____**

(please print) **(patient or legal guardian)**

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CHIROPRACTIC & WELLNESS CENTRE

Suite 116, 414 – 3 Street SW
Calgary, AB T2P 1R2 T:
403.474.7792
F: 403.719.0356

Authorization for Release of Records From Health Care Professional to Evolve Chiropractic and Wellness Center

(Please fax this form with the records to Evolve Chiropractic and Wellness Center Fax: 403.719.0356)

To: Dr._____
(please print)

Fax No#: _____

Address: _____

_____

_____

Telephone:_____

From: Patient:_____
(please print)

Date of Birth: _____

Address:_____

_____

_____

Telephone:_____

☐ **I give Evolve Chiropractic and Wellness permission to contact the above listed medical doctor to release/obtain information with respect to my care by report, letter, phone, fax, or direct email.**

PLEASE FAX THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

X-Rays _____

Laboratory Results _____

On behalf of the Evolve Chiropractic and Wellness Center,
I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient:_____
(If patient is under the age of 18 signature of Legal Guardian or Parent is required)

Date: _____

Witness: _____

Health care practitioner (please print) _____ Lic #_____

Health care practitioner (Signature) _____