*

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

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T: 403.474.7792
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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 postive 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 chiropratic care: Yes No Doctor: ____________________

List ALL medications: (prescriptions, vitamins, herbal support, 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**.

GENERAL SYMPTOMS

- Fever
- Sweats
- Fainting
- Sleep disturbance
- Fatigue
- Nervouseness
- Weight loss
- Weight gain

RESPIRATORY

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Wheezing
- Difficulty breathing
- Asthma

GENITOURINARY

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney Infection
- Prostate trouble
- Uncontrollable urine flow

NEUROLOGICAL

- Visual disturbance
- Dizziness
- Fainting
- Convulsions Headache
- Numbness
- Neuralgia (nerve pain)
- Poor coordination
- Weakness

CARDIOVASCULAR

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Hardening of arteries
- Swollen Ankles
- Poor circulation
- Palpitations
- Cold hands or Feet
- Varicose veins

GASTROINRTESTINAL

- Poor appetite
- Difficult digestion
- Heartburn
- Ulcers
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Blood in Stool
- Gallbladder/jaundice
- Colitis

EYES, EARS, NOSE, THROAT

- Eye Pain
- Double Vision
- Ringing in ears
- Deafness
- Nosebleeds
- Trouble swallowing
- Hoarseness
- Sinus infection
- Nasal drainage
- Enlarged glands

MUSCLE & JOINT

- Neck pain
- Low back pain
- Arm pain
- Shoulder pain
- Leg pain
- Knee pain
- Foot pain
- Pain/numbness down arms or legs
- Pain between shoulders swollen joints
- Spinal curvature
- Arthritis
- Fractures

FOR WOMEN ONLY

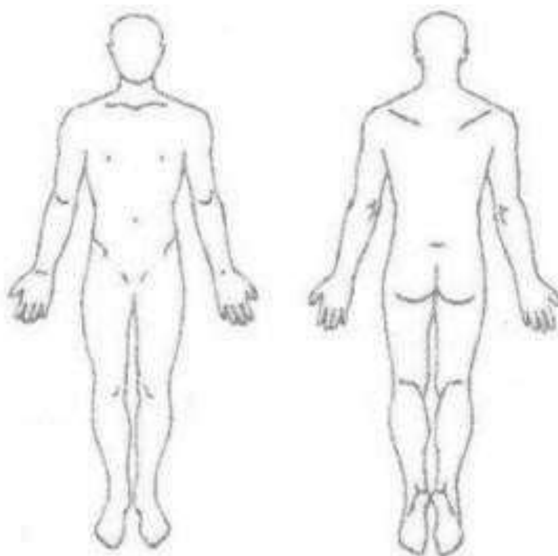
- Painful menstration
- Hot flashes
- Irregular cycle
- Cramps or back pain
- Vaginal discharge
- Nipple discharge
- Lumps in breast
- Menopausal symptoms
- Birth control pills
- Miscarriages
- Complications with pregnancy
- Pregnancy? Yes No
  Week?_______
- Other: ____________________

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 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 Osteopathic Manual Therapy

Osteopathic Therapy
I understand that the Osteopathic Manual Therapist is providing osteopathic manual therapy services within their scope of practice.

I hereby consent to my Osteopathic Manual Therapist to treat me with Osteopathic manual therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Osteopathic Manual Therapist.

I acknowledge that the Osteopathic Manual Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that osteopathic manual therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Osteopathic Manual Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Osteopathic Manual Therapist and have disclosed to the Osteopathic Manual Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I hereby acknowledge that I have discussed with the osteopathic therapist 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 o treatment as proposed to me. I understand that at any time I may withdraw my consent and treatment will be stopped.

Consent to Release Information:

______ **INITIALS**

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.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE MANUAL OSTEOPATHIC THERAPIST

I hereby acknowledge that I have read this form and discussed with the manual osteopathic therapist 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 manual osteopathic therapy treatment as proposed to me.

______________________	______________________	______________________
Name (Please Print)	Signature of Patient (or legal guardian)	Date
______________________		______________________
Signature of Manual Osteopathic Therapist		Date