*

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

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 you 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 a hard time giving 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 Substitue: (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)
- 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.

_____
INITIALS

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: _____

evolve
CHIROPRACTIC & WELLNESS CENTRE

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			