New Patient Information Package

Please read through and complete all the pages of our intake form.
*You will need to **arrive 10 minutes** before your scheduled 45-minute appointment.*

Instructions:

Print clearly in ink pen and fill out and sign pages 1 thru 3.
Read and **print only your name** on pages 4 & 6. (do not sign)

PLEASE NOTE:
We do not treat Worker's Compensation (WCB) cases

For more information on our hours, services and fees, please visit our website at:
http://www.absolutehealthincorporated.ca/

Name: _____ **ABHC #:** _____
First Middle Last

Address: _____ **Birthdate:** _____
Box No. / Apt. No. Street MM / DD / YYYY

[ ] Male [ ] Female [ ] Other

_____
City Province Postal Code

Phone: _____ **Primary Contact:**
Home Work Cell [ ] Home [ ] Work [ ] Cell

Email: _____

Would you like us to send you reminders and special offers by email? [ ] Yes [ ] No

Occupation: _____ **Employer:** _____

Emergency Contact: _____
Full Name City Phone Number Relation

How did you hear about our clinic?

[ ] Referral by: _____
[ ] Internet Search
[ ] Facebook
[ ] Rate MDs
[ ] Walking by
[ ] Driving by
[ ] Community event
[ ] Other: _____

Insurance Coverage

Please fill out this part if you have insurance coverage through: Alberta Blue Cross, Chambers of Commerce, CINUP, Cowan, Desjardins Financial, First Canadian, Great West Life, Green Shield Canada, Industrial Alliance, Johnson Inc., Manulife Financial, Maximum Benefit, Standard Life or Sun Life.

Name (as shown on your coverage card): _____
Insurance company: _____
Member ID: _____
Policy #: _____
Insured as: [ ] Insured Member [ ] Spouse [ ] Dependent [ ] Student [ ] Other
Do you have secondary coverage? [ ] Yes [ ] No

Name: _____ Signature: _____

Date: _____

Had previous chiropractic care? [ ] Yes [ ] No

Name of other chiropractor(s): _____
Chiropractor's Name / Clinic

Were X-Rays Taken? [ ] Yes [ ] No

Year of X-Rays: _____
YYYY

Is this a motor vehicle accident injury? [ ] Yes [ ] No

Is this a work-related injury? [ ] Yes [ ] No

Approx. date of last adjustment: _____
MM / DD / YYYY

Do you smoke? [ ] Yes [ ] No

Do you exercise? [ ] Yes [ ] No

Exercise Activities: _____

Do you consume alcohol? [ ] Yes [ ] No

Do you wake feeling rested? [ ] Yes [ ] No

Sleep hours /night: _____ hours

Do you use drugs? [ ] Yes [ ] No

Current medications: _____

Name of GP/ physician: _____

Do you eat regularly? [ ] Breakfast [ ] Lunch / midday meal [ ] Supper / evening meal

Rate your appetite:
[ ] Poor
[ ] Fair
[ ] Medium
[ ] Good
[ ] Excellent

Rate your diet:
[ ] Poor
[ ] Fair
[ ] Medium
[ ] Good
[ ] Excellent

Do you eat per day:
[ ] 1 meal
[ ] 2 meals
[ ] 3 meals
[ ] 4 meals
[ ] 5 meals or more

Do you take vitamins, minerals or supplements? _____
Please describe / frequency taken

Date of last dental examination: _____
MM / DD / YYYY

Have you previously been hospitalized? [ ] Yes [ ] No

If so, when? _____

Reason: _____

Experienced any falls or accidents? [ ] Yes [ ] No

Describe: _____

Had any surgeries performed? [ ] Yes [ ] No

List: _____

Ever decline to have any surgery? [ ] Yes [ ] No

List: _____

Have you ever been unconscious? [ ] Yes [ ] No [ ] Unsure

For how long? _____

Does your family have any health problems or history we should know about?
[ ] Yes [ ] No [ ] Unsure

Describe: _____

Name: _____ Signature: _____

Date: _____

Symptoms you now have or have had previously.

Please mark the corresponding box accordingly: **C** = Constant **F** = Frequent **O** = Occasional

C F O	C F O	C F O
NEUROLOGICAL	□ □ □ Enlarged glands	□ □ □ Dryness
□ □ □ Allergy	□ □ □ Enlarged thyroid	□ □ □ Hives or allergy
□ □ □ Convulsions	□ □ □ Sore throat	□ □ □ Itching
□ □ □ Dizziness	□ □ □ Tonsillitis	□ □ □ Skin rash
□ □ □ Fainting	□ □ □ Eye pain failing vision	□ □ □ Varicose vein
□ □ □ Fevers	□ □ □ Far sighted	**GENITO-URINARY**
□ □ □ Headaches	□ □ □ Gum trouble	□ □ □ Bedwetting
□ □ □ Loss of sleep	□ □ □ Hay fever	□ □ □ Blood in urine
□ □ □ Nervousness	□ □ □ Hoarseness	□ □ □ Frequent urination
□ □ □ Depression	□ □ □ Nasal obstruction	□ □ □ Loss control urine
□ □ □ Neuralgia	□ □ □ Near sighted	□ □ □ Kidney infection
□ □ □ Numbness	□ □ □ Nosebleeds	□ □ □ Painful urination
□ □ □ Sweats	**CARDIO-VASCULAR**	□ □ □ Prostate trouble
□ □ □ Loss of weight	□ □ □ Rapid heart beats	**PAIN OR NUMBNESS IN:**
□ □ □ Tremors	□ □ □ Slow heart beat	□ □ □ Shoulders
□ □ □ Vertigo	□ □ □ Swelling of ankles	□ □ □ Arms
MUSCLE & JOINT	□ □ □ Hardening of arteries	□ □ □ Hands
□ □ □ Arthritis	□ □ □ High blood pressure	□ □ □ Hips
□ □ □ Bursitis	□ □ □ Low blood pressure	□ □ □ Legs
□ □ □ Tendinitis	□ □ □ Pain over heart	□ □ □ Knees
□ □ □ Foot trouble	□ □ □ Poor circulation	□ □ □ Ankles
□ □ □ Hernia	**GASTRO INTESTINAL**	□ □ □ Feet
□ □ □ Low back pain	□ □ □ Excessive hunger	□ □ □ Painful tail bone
□ □ □ Neck pain	□ □ □ Burping or gas	□ □ □ Sciatica
□ □ □ Neck stiffness	□ □ □ Liver trouble	□ □ □ Swollen joints
□ □ □ Pain between shoulders	□ □ □ Colitis	**FOR WOMEN ONLY**
RESPIRATORY	□ □ □ Colon trouble	□ □ □ Cramps
□ □ □ Chest pain	□ □ □ Constipation	□ □ □ Heavy flow
□ □ □ Chronic cough	□ □ □ Diarrhea	□ □ □ Light flow
□ □ □ Difficulty breathing	□ □ □ Difficult digestion	□ □ □ Irregular cycle
□ □ □ Throat phlegm	□ □ □ Distension of abdomen	□ □ □ Painful cycle
□ □ □ Wheezing	□ □ □ Stomach pain	□ □ □ Discharge
EYES, EARS, NOSE, THROAT	□ □ □ Gall bladder trouble	□ □ □ Sore breasts
□ □ □ Colds	□ □ □ Hemorrhoids	**Menopausal?** [ ] Yes [ ] No
□ □ □ Crossed eyes	□ □ □ Intestinal worms	**Last menstruation date:**
□ □ □ Deafness	□ □ □ Jaundice	_____
□ □ □ Dental decay	□ □ □ Poor appetite	**Pregnant?** [ ] Yes [ ] No
□ □ □ Asthma	□ □ □ Nausea	**Due Date:**
□ □ □ Ear aches	□ □ □ Vomiting	_____
□ □ □ Ear discharges	□ □ □ Vomit blood	
□ □ □ Ear noises	**SKIN**	
□ □ □ TMJ	□ □ □ Boils	
□ □ □ Sinus infections	□ □ □ Bruise easily	

Name: _____ Signature: _____

Date: _____

Payment Contract

Dated: _____

Alberta Health Care Insurance Plan has been delisted effective July 1, 2009.

I understand that I am responsible to pay **$95 for the initial consultation fee**, and **$53 per subsequent visit(s)**. Seniors pay **$42 per subsequent visit(s).**

I clearly understand and agree that **all charges that are not covered by my insurance company are charged directly to me and that I am personally responsible for payment.**

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ _____

Signature (or Legal Guardian) Absolute Health Incorporated Witness Signature

_____ _____

Printed Name Absolute Health Incorporated Representative

Cancellation & Missed Appointment Policy

Dated: _____

I clearly understand and agree that missed appointments, or appointment changes made less than six (6) business hours prior, are charged a **$25 missed appointment fee**.

If I am unable to make my scheduled appointment, I will advise Absolute Health Incorporated **at least six (6) business hours before my scheduled appointment** by calling their office at (780) 448-5888, and I will leave a message if I get through to the answering machine.

I understand that Absolute Health Incorporated is sensitive to extenuating circumstances which arise and will be considerate of such when enforcing this policy. I agree to discuss any such circumstances at the soonest opportunity with the staff or practitioners at Absolute Health Incorporated, as soon as I possibly can.

_____ _____

Signature (or Legal Guardian) Absolute Health Incorporated Witness Signature

_____ _____

Printed Name Absolute Health Incorporated Representative

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
Informed 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.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Signed the _____ day of _____, 201__.

_____	_____
Patient Signature (or Legal Guardian)	Chiropractor Signature
_____	_____
Printed Name	Printed Name