Consultation Admittance Form

Last Name:	First Name:	Gender: M / F / Other
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work) ( )	Phone (Cell) ( )

Alberta Health Care #	Third Party Insurance #
Emergency Contact Name:	Emergency Contact Phone ( )

Date of Birth:	Age:	Height:	Weight:
Occupation:		Marital Status: Single Married Widowed Divorced	
Email address: (optional)		(Email will be used for appointment reminders and office updates.)	

How did you hear about us?

Please check all answers and fill in the blanks where appropriate.

Reason(s) for appointment: _____

When did your condition begin? _____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when? _____

_____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No On what date did the accident occur? _____

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? _____

List all previous surgeries, illnesses, injuries (including MVA): _____

_____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Date: _____

Family doctor name: Dr. _____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: _____

_____

_____

Date: _____ Patient signature: _____

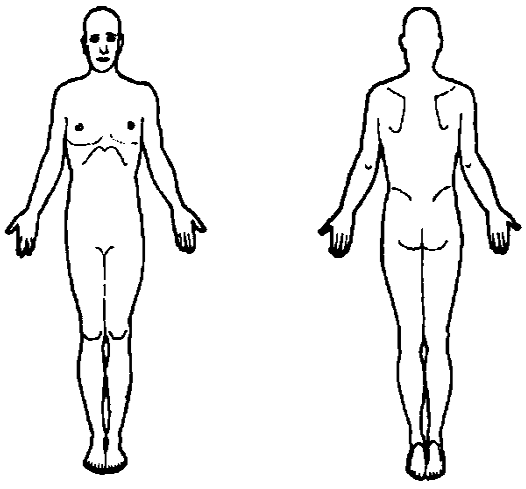
Health History Questionnaire

Patient name _____ **Date** _____

Have you ever been diagnosed or told you have any of the following? Circle 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---------- Yes No
   Where? _____
6. Heart or blood diseases---------- Yes No
7. Bone spurs on the neck bones (cervical sprain)---------- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) ---------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ---------- Yes No
10. Were you ever a smoker? ---------- Yes No
    From _____ to _____
11. Do you take medication on a regular basis? ---------- Yes No
12. Visual disturbances (blurring, loss, double vision) ---------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ---------- Yes No
14. Slurred speech or other speech problems ---------- Yes No
15. Difficulty swallowing ---------- Yes No
16. Dizziness ---------- Yes No
17. Loss of consciousness, even momentary blackouts ---------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ---------- Yes No
19. Sudden collapse without loss of consciousness---------- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain

Systems Review

Patient Name: _____ **Date:** _____

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Enlarged glands	Spinal curvature	Miscarriages
	Arthritis	Complications with pregnancy
	Fractures	Pregnant? Y / N Week?
		Other:

CHIROPRACTIC CASE HISTORY

PATIENT NAME			**GENDER M / F**
CHART #	**ABH #**	**INSURANCE #**	**DATE**
HOME ADDRESS			
PHONE (H) ( )	**PHONE (W) ( )**	**PHONE (C) ( )**	
MARITAL STATUS S M W D	**DATE OF BIRTH**	**AGE**	

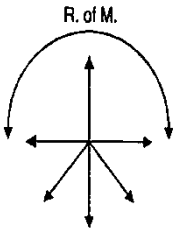
1	**CHIEF COMPLAINT** (include symptoms)	
2	**HISTORY of CONDITION** (mode of onset, course, prior treatment, prior occurrence)	
3	**FREQUENCY**	
4	**INTENSITY**	**VAS Pain Intensity Scale** 1 2 3 4 5 6 7 8 9 10 Least Worst
5	**CHARACTER**	
6	**DURATION**	
7	**AGGRAVATING FACTORS**	
8	**RELIEVING FACTORS**	
9	**ASSOCIATED SYMPTOMS** (pain radiations, nausea, etc.)	
10	**SYSTEMS REVIEW**	
11	**MEDICAL HISTORY** (past illness, surgeries, past injuries, etc.)	
12	**RELATED FAMILY HISTORY**	
13	**PSYCHO-SOCIAL HISTORY**	
14	**MEDICATIONS, DRUGS, VITAMINS, SUPPLEMENTS** (past & present)	
15	**RECREATIONAL or OCCUPATIONAL FACTORS** (e.g., sports, computer work, heavy lifting, etc.)	
16	**SECONDARY COMPLAINTS**	
17	**X-RAY REPORT** (narrative)	
17	**IMPRESSION** (summary of x-ray report)	

PHYSICAL EXAMINATION

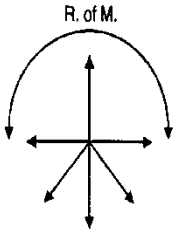
PATIENT NAME:

SUMMARY OF FINDINGS

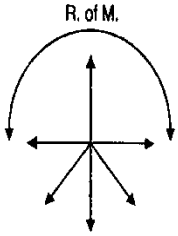
R. of M.

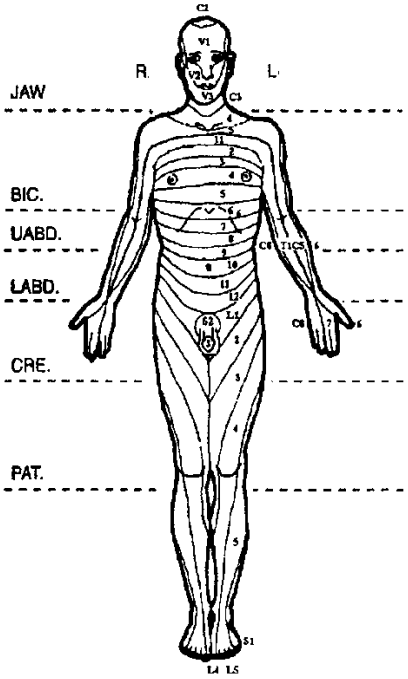


R. of M.



R. of M.





LEFT	SEGMENT	RIGHT
	Occ	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
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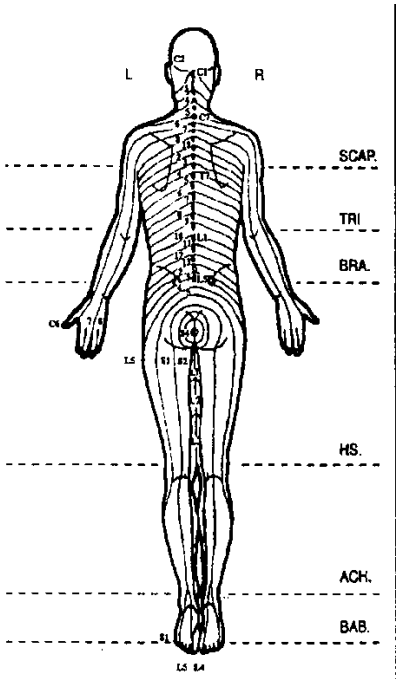
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	S/I	



DIAGNOSIS & PHYSICAL IMPRESSION:
Narrative diagnosis preferred.
ICD-9 codes = insufficient.

TREATMENT PLAN: modality of care, frequency and duration of care, and re-evaluation interval. (Modality e.g., SMT, ART, Graston, laser, ultrasound, electrical stimulation, controlled exercise plan, lifestyle counseling, etc.)

Payment Contract

Dated: _____

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

I understand that I am responsible to pay **$99 for the initial visit, and $62 per subsequent visit(s)**. Seniors and children pay **$49 per subsequent visit(s)**. **Extended follow-up visits are $89.**

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

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 MEETWITH 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.

_____ Date: _____ 20____.
Name (Please Print)

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

_____ Date: _____20____
Signature of Chiropractor

SOAP/Progress Notes

Patient name: ____

Date	OC	T1	T7	L1	
	C1	T2	T8	L2	
	C2	T3	T9	L3	
Q	C3	T4	T10	L4	
	C4	T5	T11	L5	
	C5	T6	T12	SI	
X-ray	C6			Sac	
	C7				

Date	OC	T1	T7	L1	
	C1	T2	T8	L2	
	C2	T3	T9	L3	
Q	C3	T4	T10	L4	
	C4	T5	T11	L5	
	C5	T6	T12	SI	
X-ray	C6			Sac	
	C7				

Date	OC	T1	T7	L1	
	C1	T2	T8	L2	
	C2	T3	T9	L3	
Q	C3	T4	T10	L4	
	C4	T5	T11	L5	
	C5	T6	T12	SI	
X-ray	C6			Sac	
	C7				

Date	OC	T1	T7	L1	
	C1	T2	T8	L2	
	C2	T3	T9	L3	
Q	C3	T4	T10	L4	
	C4	T5	T11	L5	
	C5	T6	T12	SI	
X-ray	C6			Sac	
	C7				

Date	OC	T1	T7	L1	
	C1	T2	T8	L2	
	C2	T3	T9	L3	
Q	C3	T4	T10	L4	
	C4	T5	T11	L5	
	C5	T6	T12	SI	
X-ray	C6			Sac	
	C7				

Date	OC	T1	T7	L1	
	C1	T2	T8	L2	
	C2	T3	T9	L3	
Q	C3	T4	T10	L4	
	C4	T5	T11	L5	
	C5	T6	T12	SI	
X-ray	C6			Sac	
	C7				