*

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 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 chiropractic care: ☐Yes ☐No Doctor: _____

List ALL medications: (prescriptions, vitamins, herbal supports, 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

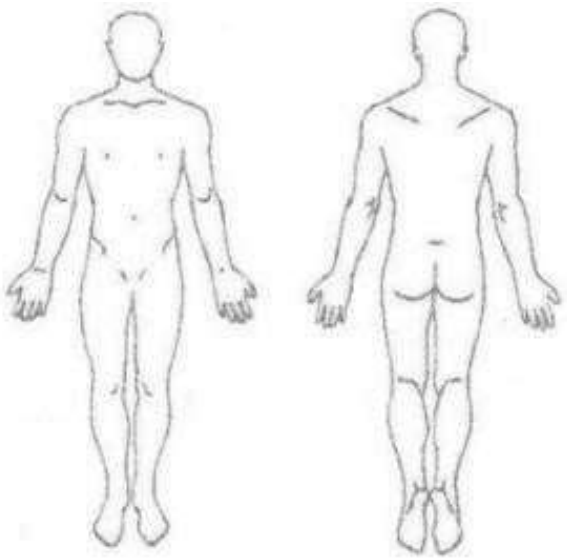
- ☐Painful menstration
- ☐Hot flashes
- ☐Irregular cycle
- ☐Cramps or back pain
- ☐Vaginal discharge
- ☐Nipple discharge
- ☐Lumps in breast
- ☐Menopausal symptoms
- ☐Birth control pills
- ☐Miscarriages
- ☐Complications with pregnancy
- ☐Pregnancy? ○Yes ○No
  Week?_____
- ☐Other: _____

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**

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
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 MEET WITH 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.

_____
Name (Please Print)

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

_____ Date: _____20____
Signature of Chiropractor

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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 MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have read this form and 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 acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date

CCPA 09.16

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)
- Insurer
- Employer
- 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 physiotherapist 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 physiotherapy treatment as proposed to me.

_____ _____
Name (Please Print) Date

_____
Patient Signature (or Legal Guardian)