DOUGLAS SQUARE CHIROPRACTIC

#140, 11520 – 24 St. S.E. Calgary, Alberta T2Z 3E9
phone (403) 279-0800 fax (403) 279-7277

CHIROPRACTIC CHIROPRATIQUE Alberta MEMBER

Confidential Patient Information

Full Name: _____
first middle last

Address: _____ Postal Code _____

Phone # home: _____ work/cell: _____ Email: _____

Birthday: _____ Age: _____ Sex: **M F X** Height: _____ Weight: _____

Marital status: Married Single Divorced Widowed

Name of Spouse: _____ # of children: _____

Employer: _____ Occupation: _____

Physician's name: _____ Alberta Health Care #: _____

Emergency Contact: _____ phone # _____

Your major complaint or symptom is? _____

Have you ever been under Chiropractic care? **Y N**

How did you hear about our office? _____

Is this a motor vehicle accident case? **Y N** Date of accident? _____ a WCB case? **Y N**

The fee schedule is as follows:

Service	**Adult**	**Youth (<18) & Senior >64**
Initial Examination, Consultation & Treatment	$95	$95
Chiropractic Treatment	$60	$45
Chiropractic & Active Release Therapy	$72	$55
Shockwave	$85	$85
Re-Exam	$75	$75
Missed appointment without notice	$25	$25

We can submit for chiropractic services on your behalf for Sun Life & Great West Life but payment is due at the time of service. We can direct bill Blue Cross and Greenshield for chiropractic services.

Payment is due when the service is rendered. We accept cash, cheque, interac, mastercard and visa. ***You*** are responsible for any outstanding charges.

HEALTH INFORMATION:

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

Check any of the following conditions / diseases you have had:

☐ appendicitis ☐ anorexia ☐ endometriosis ☐ heart attack / angina
☐ high blood pressure ☐ stroke ☐ asthma ☐ cancer
☐ diabetes ☐ pneumonia ☐ epilepsy ☐ arthritis
☐ mental disorder ☐ AIDS / HIV ☐ anemia ☐ lupus
☐ fibromyalgia ☐ alcoholism ☐ colitis ☐ allergies _____
_____

Check any of the following you have or have had in the past:

☐ low back pain ☐ pain between shoulders ☐ jaw pain **Females only:**
☐ neck pain ☐ hip pain ☐ elbow pain are you pregnant? Yes No Maybe
☐ headaches / ☐ knee pain ☐ wrist pain birth control pills? Yes No
☐ migraines ☐ foot pain ☐ shoulder pain hormone replacement? Yes No

Nervous System
☐ concussion
☐ numbness
☐ dizziness
☐ paralysis
☐ depression
☐ fainting
☐ convulsions
☐ cold/tingling hands/feet

EENT
☐ vision problems
☐ dental problems
☐ ear aches
☐ hearing problems

Genito-Urinary
☐ discoloured urine
☐ bladder trouble
☐ painful urination
☐ prostate problems
☐ excessive urination

C-V-R
☐ chest pain
☐ short of breath
☐ blood pressure problems
☐ chest congestion
☐ ankle swelling
☐ cigarette smoker
☐ blood clots

Gastrointestinal
☐ poor appetite
☐ excessive appetite
☐ excessive thirst
☐ hemorrhoids
☐ constipation
☐ frequent nausea
☐ vomiting
☐ diarrhea
☐ irritable bowel syndrome (IBS)
☐ abdominal cramps
☐ weight gain/loss
☐ liver trouble/jaundice
☐ gall bladder problems

Male/Female
☐ menstrual irregularity
☐ menstrual cramps
☐ vaginal pain/infections
☐ breast pain/lumps
☐ prostate/sexual dysfunction
☐ osteoporosis

list any surgeries you have had: _____
_____

list any other conditions or problems you feel may be important
_____
_____

Pertinent Family History:
_____
_____

Current Problem:

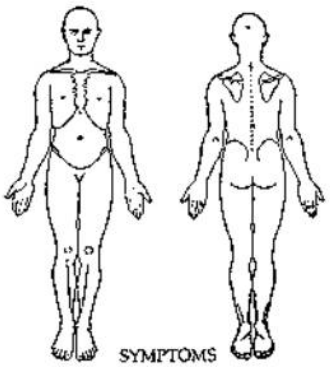
Where is your pain / symptom: (draw on figure) _____

When & How did it start? _____

_____

_____

_____



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

DOUGLAS SQUARE CHIROPRACTIC

CONSENT FOR RELEASE OF PERSONAL INFORMATION WAIVER

I, _____, in the city of Calgary, Alberta, understand that Douglas Square Chiropractic & Massage privately secures my health care records and personal information. I understand that they will not release any information about myself without being able to verify the identity of the inquirer.
Without accurate consent or verification, Douglas Square Chiropractic & Massage holds the explicit right to not release any information at their own discretion.
By signing this form I agree to the following, which I have initialed below:

Release of information to myself via: Initial (below)

Phone (personal identifier questions may be asked): _____
Email (must provide email address in-person/intake): _____

Release of information to a third-party: Initial (below)

Insurance provider (must sign for direct billing, WCB, MVA): _____
Other healthcare provider (i.e. Your MD): _____
A diagnostic imaging facility (i.e. X-Rays, Ultrasound, MRI): _____
Approved third party (i.e. translator, family member, etc.): _____
Please provide name(s) of approved third party: _____

Initialing below allows Douglas Square Chiropractic & Massage to contact the third parties mentioned above to access your personal information for the sole purpose of collecting healthcare- relevant billing information that improves your care/treatment at DSC&M.

_____ (Initial) I Agree _____ (Initial) Refuse

Personal information is collected and used for a variety of reasons such as: patient care, scheduling, billing and quality assurance. We treat personal information with the same care as we do personal health information. We take reasonable steps to ensure it is protected, remains confidential and is only accessed by those authorized to do so and for the purpose in which it was collected.
I hereby acknowledge and declare the terms of this authorization for release of information are fully understood by me,

_____ _____
(Name) (Witness Name)

_____ _____
(Signature) (Witness Signature)

_____ _____
(Date) (Date)