**PINES CHIROPRACTIC & LASER CENTER**

**Consultation Admittance Form**

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name: | Gender:  |
| 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 Common-Law Other |
| Email address: (optional) | (Email will be used for [ACAC member to customize, e.g., appointment reminders, receipts, birthday emails, etc.] ) |
|  |

**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?

1. Heart or blood diseases Yes No
2. Bone spurs on the neck bones (cervical sprain) Yes No
3. Whiplash injury (flexion-extension injury, cervical sprain) Yes No
4. Have you or any of your relatives ever suffered a stroke? Yes No
5. Were you ever a smoker? Yes No

 From to

1. Do you take medication on a regular basis? Yes No
2. Visual disturbances (blurring, loss, double vision) Yes No
3. Hearing disturbances (loss, ringing, other noise) Yes No
4. Slurred speech or other speech problems Yes No
5. Difficulty swallowing Yes No
6. Dizziness Yes No
7. Loss of consciousness, even momentary blackouts Yes No
8. 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

1. 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** |
| FeverSweatsFaintingSleep disturbanceFatigueNervousnessWeight lossWeight gain | Chronic coughSpitting up phlegmSpitting up bloodChest painWheezingDifficulty breathingAsthma | Frequent urinationPainful urinationBlood in urinePus in urineKidney infectionProstate troubleUncontrollable urine flow |
| **NEUROLOGICAL** | **CARDIOVASCULAR** | **GASTROINTESTINAL** |
| Visual disturbanceDizzinessFaintingConvulsionsHeadacheNumbnessNeuralgia (nerve pain)Poor coordinationWeakness | Rapid beating heartSlow beating heartHigh blood pressureLow blood pressurePain over heartHardening of arteriesSwollen anklesPoor circulationPalpitationsCold hand or feetVaricose veins | Poor appetiteDifficult digestionHeartburnUlcersNauseaVomitingConstipationDiarrheaBlood in stoolGallbladder/jaundiceColitis |
| **EYES, EARS, NOSE, THROAT** | **MUSCLE & JOINT** | **FOR WOMEN ONLY** |
| Eye painDouble visionRinging in earsDeafnessNosebleedsTrouble swallowingHoarsenessSinus infectionNasal drainageEnlarged glands | Neck painLow back painArm painShoulder painLeg painKnee painFoot painPain/numbness down arms or legsPain between shoulders swollen jointsSpinal curvatureArthritisFractures | Painful menstruationHot flashesIrregular cycleCramps or back painVaginal dischargeNipple dischargeLumps in breastMenopausal symptomsBirth control pillsMiscarriagesComplications with pregnancyPregnant? Y / N Weeks?Other:  |

**LASER PATIENTS ONLY – PAIN ASSESSMENT**



**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

**Chiropractic**

* **Adults** (18-59)

First time exam (required by all first time patients)…………………………………………………… $45

Chiropractic treatments………………………………………………………………………………….. $45

Full time post-secondary students……………………………………………………………………… $40

* **Students** (12-17)

First time exam (required by all first time patients)…………………………………………………… $45

Chiropractic treatments………………………………………………………………………………….. $40

* **Children** (under 12)

First time exam (required by all first time patients)…………………………………………………… $30

Chiropractic treatments………………………………………………………………………………….. $30

* **Senior** (60 or older)

First time exam (required by all first time patients)…………..………………………………………. $30

Chiropractic treatments……………………………………………..…………………………………… $40

\*\*\*Treatment for seniors are $20 on the first Wednesday of each month or $10 if BC covers $25\*\*\*

**Muscle Therapy**

**Glenda:**  30 minutes - $50 45 minutes - $70 60 minutes - $90

**Darryl**: 30 minutes - $55 45 minutes - $75 60 minutes - $100

**Laser Therapy**

* **Laser Assessment**………………………………………………………………….$40
* **Laser Treatments**………………………………………………to be determined during assessment

Patient Signature: Date:

**Clinic Cancellation Policies**

For **Chiropractic & Laser Treatments** we require a minimum of

4 hours advance notice for all cancellations

For **Muscle Therapy** we require a minimum of 24 hours advance notice for all cancellations

If you have an appointment booked and do not provide the required hours of notice of cancellation or do not show for the appointment, the fee will be EQUAL to the price of the appointment scheduled

**Any outstanding charges are required to be paid in full prior to receiving your next treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have read and understood the above clinic policies and I agree that I will be responsible for all outstanding charges that may apply

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature Witness Signature