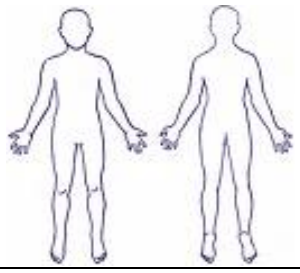
active BACK TO Health centre

PATIENT HEALTH HISTORY FORM

Name:	Today's Date:
Address:	Date of Birth (MM/DD/YY):
City:	Home Phone:
Province:	Business Phone:
Postal Code:	Cell Phone:
Email address:	
Would you like us to send newsletters and special offers to you? Yes/No	
Occupation:	Employer:
Alberta Health Care #:	Gender: M or F
Do you have insurance coverage for chiropractic and massage?	
Physician:	Last Visit:
Height:	Weight:
Emergency Contact: Phone:	Relationship:
How did you hear about our clinic? (Please circle one of the following below) Google Yelp Rate MD Website Friend/Family Health Care Professional	
Name of health care professional or friend who referred you:	
Please list any medications (prescribed or over the counter), vitamins or supplements that you are currently taking. Please include dosage.	
Have you had chiropractic/massage before? Yes / No	Last Visit:
Primary reason for your visit today:	
Major complaint:	
Is this a Motor Vehicle Accident Claim? Yes / No	Date of MVA:
Is this a work related injury? Yes / No	Date of Injury:
Please indicate if you have had the following done:	
Xrays / MRI / Ultrasound	Date:
Please indicate affected areas: 	
PLEASE DO NOT WRITE BELOW THIS LINE-DOCTOR ONLY:	
Diagnosis:	
Treatment Alert:	

Please check off any of the following health conditions that apply to you:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Varicose Veins
- ☐ Blood Clotting Disorder
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Vision or Hearing Disturbances
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Shoulder Pain
- ☐ Neck Pain
- ☐ Arthritis
- ☐ Sexually Transmitted Disease (STD or HIV)
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Circulation Problems
- ☐ Nervous System Disorder
- ☐ Skin Disorders/Sensitive Skin/Eczema
- ☐ Asthma
- ☐ Dizziness/Vertigo/Tinnitus
- ☐ Numbness or Tingling
- ☐ Nausea

Any other underlying health condition?

Do you faint easily? Yes/No
Do you wear contact lenses? Yes/No
Do you bruise easily? Yes/No
Do you have frequent headaches? Yes/No
Do you have a cardiac pacemaker? Yes/No
Do you have any spinal problems? Yes/No
Do you suffer from migraines? Yes/No

Have you ever had surgery? Yes/No If yes, please explain:
Do you have any allergies? Yes/No If yes, please specify:
Do you have any other medical conditions that I should be aware of? Yes/No If yes, please explain:
Women: Are you pregnant? Yes/No Nursing? Yes/No Taking Birth Control Pills? Yes/No How many pregnancies? Are you menopausal?
What % of your day is spent sitting: standing: walking:
Do you do any lifting? Yes/No How much and how often?
Do you exercise? Yes/No What activities? How many days per week?
Rate your stress level on a scale of 1 to 10 (10 being high): at work: /10 at home: /10
Rate your quality of sleep on a scale of 1 to 10 (10 being excellent): /10
Do you wake rested? Yes/No How many hours of sleep per night:
Sleeping position: Back Stomach Left Side Right Side
How many pillows do you use? Is your mattress: Firm Soft Medium Other?
Rate your appetite on a scale of 1 to 10 (10 being excellent):
How many cups of caffeinated beverages do you consume per week?
How many ounces of alcohol do you consume per week?
Do you smoke? Yes/No How much per week:

ABOUT OUR OFFICE

Welcome to the Active Back to Health Centre. Our goal is to provide you with the highest quality health care in an encouraging and friendly environment. You will experience competent and professional health care with a focus on natural approaches and treatments.

Understanding a few things that will make your time with us more comfortable and effective.

- Compliance to the recommended treatment program is one of the most important factors in recovering and maintaining your health. We have developed protocols that integrate the best of chiropractic, massage, nutritional support, naturopathic and exercise to give you every advantage for a safe, effective and speedy journey back to health and wellness.
- We have a policy that ensures that each individual in our clinic is entitled to:
  - A nurturing environment safe from abuse
  - Confidentiality of patient information
  - Accurate reporting of findings
  - Appropriate referral when required
  - Each person is treated with sincerity, honesty and dignity
- Please inform us immediately if your injury is work related. The Workers Compensation Board covers 100% of the chiropractic fees.
- Payment is made in full at the time the services are rendered unless prior arrangements have been made with the front desk staff or the treating therapist. Our staff is available to discuss financial arrangements.
- Payments can be made in Cash, Cheque, Visa, Mastercard or Interac.
- Many private insurance companies provide extended health care benefits. These policies need to be confirmed by you. Active Back to Health will provide you with receipts to be submitted by you to your insurance company.
- **Please provide a minimum of 24 hours notice for cancellation and/or to change any appointment. Failure to do so may result in a missed appointment fee.**

FEE SCHEDULE:
SERVICES RENDERED

Chiropractic Follow-Up	$65
First Visit/ Re-Exams	$115/$90
Laser	$60
Laser add-on	$20
NET	$65
NET + Chiropractic	$100
Acupuncture First Visit	$105
Acupuncture Regular Visit	$90

Dr. Harrison's Fee Schedule

Cranial Sacral Therapy	$125
Body Talk	$125
Visceral Manipulation	$125
Chiropractic Re-Exams	$115

Naturopathic Services

Initial Visit	$190.00
Follow up Visit, 30 minutes	$95.00

Massage Therapy Fees (+GST)

90 minute treatment	$140.00
75 minute treatment	$125.00
60 minute treatment	$105.00
45 minute treatment	$85.00
30 minute treatment	$65.00

Physiotherapy

Initial Assessment	$115.00
Subsequent Treatment	$90.00

I have read and understand the above policies.

Patient Name:_____ Patient Signature:_____

Date:_____

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