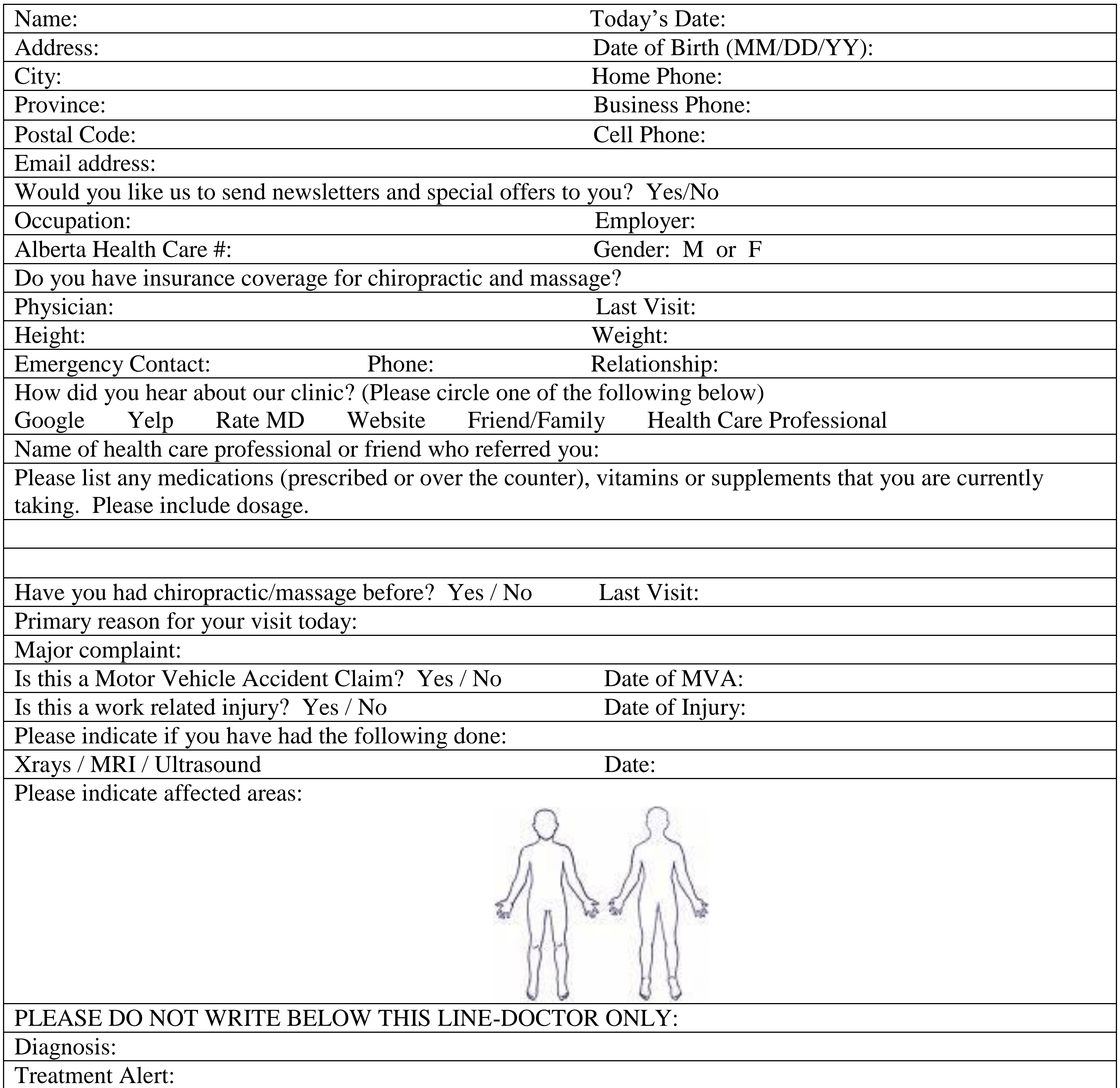
active BACK TO Health centre

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

Any other underlying health condition?

Do you faint easily?	Yes/No	Do you have frequent headaches?	Yes/No
Do you wear contact lenses?	Yes/No	Do you have a cardiac pacemaker?	Yes/No
Do you bruise easily?	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

Service	Fee
Chiropractic Follow-Up	$60
First Visit/Re-Assessment	$110/$115
Laser	$55
Laser add-on	$20
Acupuncture First Visit	$100
Acupuncture Regular Visit	$85
Cranial Sacral Therapy	$115
Body Talk	$115
Visceral Manipulation	$115
Naturopathic Services	
Initial Visit	$185
Follow up Visit, 30 minutes	$93
Massage Therapy Fees	
90 minute treatment	$135
75 minute treatment	$120
60 minute treatment	$100
45 minute treatment	$80
30 minute treatment	$60
Psychotherapist	
1 hour counseling (individual)	$160
1 hour counseling (couple)	$175
1 hour counseling (family)	$180
Registered Psychologist	
1 hour counseling	$180

I have read and understand the above policies.

Patient Name:___________________________________ Patient Signature:____________________________________

Date:____