



CHIROPRACTIC PATIENT REGISTRATION

Please print clearly

Name: _____ Gender: M / F

Last

First

M.I.

Address: _____

Street

City

Prov

Postal Code

Date of Birth (DD/MM/YYYY): _____ Age: _____ Height: _____ Weight: _____

Phone (Home) (____) _____

Email: _____

Phone (Cell) (____) _____

Occupation: _____

Phone (Work) (____) _____

Referred by: _____

Relationship to you: _____

Alberta Health Care #: _____

EMERGENCY CONTACT INFORMATION

Work Extended Benefits ID: _____

Name: _____

Insurance Company: _____

Phone Number: _____

Plan / Group #: _____

Relationship: _____

Cardholder Name: _____

Our clinic provides text/email reminders. To receive these services please provide either:

Cell phone service provider: _____ Email address: _____

Initial Assessment and Treatment \$85.00

Subsequent Chiropractic Visit \$55.00

Visit may include but is not limited to:

-Consultation

-Adjustment

-Joint work

-Exercise-Muscle release therapy

-Electro therapy

Please be aware you are responsible for the balance of the above fee schedule. Fees are due and payable at the time of service unless prior arrangements have been made.

Date: _____

Patient Signature: _____

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? _____

Do you use Custom Foot Orthotics? Yes No If no, would you like to be fitted? Yes No

List all previous surgeries, illnesses, injuries (including MVA): _____

Have you had previous chiropractic care? Yes No Dr. _____ Date: _____

Family doctor name: Dr. _____ Phone #: _____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: _____

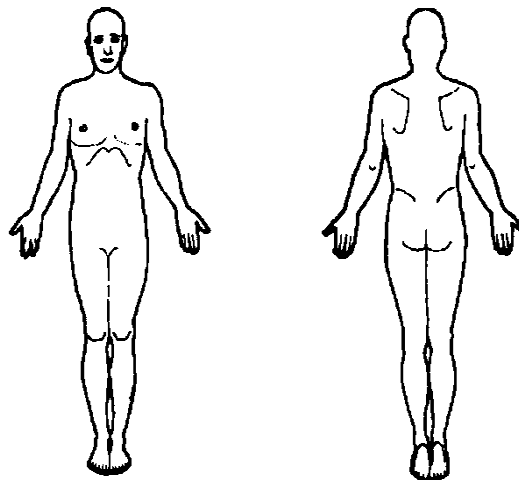
Date: _____ Patient signature: _____

Health History Questionnaire

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? _____
6. Heart or blood diseases----- Yes No
7. Bone spurs on the neck bones (cervical sprain) ----- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)----- Yes No
9. Have you or any of your relatives ever suffered a stroke? ----- Yes No
10. Were you ever a smoker? ----- Yes No
From _____ to _____
11. Do you take medication on a regular basis? ----- Yes No
12. Visual disturbances (blurring, loss, double vision) ----- Yes No
13. Hearing disturbances (loss, ringing, other noise) ----- Yes No
14. Slurred speech or other speech problems ----- Yes No
15. Difficulty swallowing ----- Yes No
16. Dizziness ----- Yes No
17. Loss of consciousness, even momentary blackouts ----- Yes No
18. 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
19. 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

Circle any conditions that are **presently** causing you a problem.

Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hand or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EYES, EARS, NOSE, THROAT	MUSCLE & JOINT	FOR WOMEN ONLY
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	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	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other:



Electronic Transmission Authorization and Consent Form

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted,

I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

Date: _____

Patient Signature: _____

Print Name: _____