Kinetic Health
Chiropractic Clinic

PATIENT ADMITTANCE FORM

Date:	First Name:	Last Name:	Initials:

CONTACT INFORMATION

Home Address:	Phone (H):
City/Province:	Phone (C):
Postal Code:	Phone (W):

EMAIL INFORMATION

Email:	Patient Initials:	Date:

☐ You agree that by providing this email address, and by initialing this document, that you have read the following Terms of Usage, and agree that we can send you email communications to confirm appointments, provide exercise and health instructions, provide health updates, service updates, and send information through clinic newsletters. You can opt-out of this service at any time.

Terms of Usage: Email addresses are strictly confidential and are never given out to other sources. We believe in a no- spam policy. We use emails to confirm appointments, provide you with exercises, health updates and clinical newsletters. Email also provides you with a means of asking your practitioner questions when they are not able to answer phone calls while treating patients. At any time, you can choose to opt-out of our email information services.

PATIENT DETAILS

Sex:	Occupation:
Date of Birth:	Marital Status:
Age:	Significant Other:

HEALTH INFORMATION

Alberta Health Care #:
Family Physician:
Phone # for Physician:

EMERGENCY CONTACTS

Name:	Phone (H):
Relationship:	Phone (C):

INSURANCE INFORMATION

Insurance Company:	Policy Holder's Name:	Policy #:	ID #:

I _____ authorize Kinetic Health to submit my claims information electronically, on behalf of myself, or for _____ . _____ _____
(Name of Policy Holder) *(Name of Child or Spouse)* *(Date)* *(Signature)*

CHIEF COMPLAINT

DOCTOR

Do you want to see a particular physician?

☐ It does not matter
☐ Dr. B. Abelson
☐ Dr. E. Mylonas

CLINIC STAFF ENTRIES

Blood Pressure: _____
Pulse: _____
Temperature: _____
Height: _____
Weight: _____
Respiration: _____

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CHIEF COMPLAINTS

DESCRIBE THE ONSET OF THIS CONDITION.

Is your complaint related to a fall, an accident, or an auto accident? Was the onset gradual or sudden? Please describe!

WHEN DID YOUR CONDITION BEGIN (DURATION)? WHAT IS ITS FREQUENCY OF OCCURRENCE?

DO YOU HAVE A HISTORY OF SIMILAR CONDITIONS OCCURRING IN THE PAST? IF YES, PLEASE PROVIDE DETAILS.

HOW DOES YOUR CONDITION INTERFERE WITH WORK OR ACTIVITIES OF DAILY LIVING?

IS THE CONDITION GETTING:

- ☐ Worse
- ☐ Same
- ☐ Better
- ☐ Consistent
- ☐ Recurring

IS THERE A PARTICULAR TIME OF DAY WHEN YOUR CONDITION IS WORSE?

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ During the Night
- ☐ After long periods of activity

IS THIS AN AUTO ACCIDENT CASE (MVA), OR HAVE YOU RECENTLY BEEN IN AN ACCIDENT?

- ☐ NO
- ☐ YES
- ☐ *If YES please inform our front desk so that we can process your case correctly.*

IS THIS A WORKER'S COMPENSATION BOARD (WCB) CASE?

- ☐ NO
- ☐ YES
- ☐ *If YES please inform our front desk so that we can process your case correctly.*

HOW WOULD YOU DESCRIBE THE CHARACTER OF THE PAIN THAT YOU ARE EXPERIENCING?

- ☐ Aching/Throbbing
- ☐ Burning
- ☐ Cramping
- ☐ Dull pain
- ☐ Hot or burning
- ☐ Intermittent
- ☐ Numbness
- ☐ Persistent
- ☐ Radiating Pain
- ☐ Severe
- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Tingling
- ☐ Other _____

WHAT AGGRAVATES YOUR CONDITION?

WHAT RELIEVES (ALLEVIATES) YOUR CONDITION?

DOES THE PROBLEM SPREAD TO ANY OTHER AREA OF THE BODY OR IS IT LOCALIZED?

WHAT TYPES OF TREATMENT HAVE YOU RECEIVED FOR THIS CONDITION? PLEASE LIST AND PROVIDE DETAILS. INCLUDE NAMES OF PRACTITIONERS IF KNOWN.

WHAT WERE THE RESULTS OF PREVIOUS TREATMENTS?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent
- ☐ Other (Provide details)

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GENERAL SYSTEMS REVIEW

RESPIRATORY

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Cough
- ☐ Emphysema
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Pneumonia
- ☐ Smoker
- ☐ Trouble Swallowing

SKIN

- ☐ Acne
- ☐ Boils
- ☐ Bruising
- ☐ Color changes
- ☐ Dermatitis
- ☐ Eczema
- ☐ Fungal Infection
- ☐ Herpetic Infection
- ☐ Itching
- ☐ Lumps
- ☐ New Rashes/Moles
- ☐ Pain
- ☐ Polyps
- ☐ Psoriasis
- ☐ Rashes
- ☐ Scars
- ☐ Shingles
- ☐ Steroid Therapy
- ☐ Swelling

VISION

- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Dyslexia
- ☐ Glaucoma
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Tearing
- ☐ Vision Loss

CARDIOVASCULAR

- ☐ Angina
- ☐ Ankle or leg swelling (Edema)
- ☐ Arrhythmia's
- ☐ Arteriosclerosis
- ☐ Blood Clots
- ☐ Chest Pain
- ☐ Cold hands, feet
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Pain When Walking
- ☐ Leg Swelling
- ☐ Palpitations
- ☐ Shortness of breath

EARS

- ☐ Buzzing
- ☐ Discharges
- ☐ Dizzy
- ☐ Hearing Loss
- ☐ Infection
- ☐ Ringing
- ☐ Tinnitus

HEAD

- ☐ Concentration
- ☐ Concussion
- ☐ Headaches (Tension or Migraines)
- ☐ Insomnia
- ☐ Loss of consciousness
- ☐ Memory Decline

MOUTH/THROAT

- ☐ Bleeding Gums
- ☐ Gum Disease Dental Decay
- ☐ Sore Throat
- ☐ Toothache

GASTRO-INTESTINAL

- ☐ Abdominal pain
- ☐ Appendicitis
- ☐ Appetite loss
- ☐ Black Stool
- ☐ Blood in Stool
- ☐ Colitis
- ☐ Chronic Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Digestive Disorders
- ☐ Gall Bladder Problem
- ☐ Gas and Bloating
- ☐ Heart Burn/Indigestion
- ☐ Irritable Bowel Syndrome
- ☐ Nausea
- ☐ Recent Bowel Habit Change
- ☐ Stomach Cramps
- ☐ Ulcers
- ☐ Vomiting
- ☐ Weight Loss

URINARY

- ☐ Bed Wetting
- ☐ Bladder and kidney infections
- ☐ Blood in Urine
- ☐ Burning sensation
- ☐ Decreased Force
- ☐ Decreased Frequency
- ☐ Dribbling
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Increased Frequency
- ☐ Infections
- ☐ Kidney Stones
- ☐ Recent Urinary Change

VASCULAR

- ☐ Anemia
- ☐ Cold Hands and Feet
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Hemorrhoids
- ☐ Leg pain after walking
- ☐ Raynaud's Disease
- ☐ Swelling
- ☐ Thrombophlebitis
- ☐ Varicose Veins

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Back Ache
- ☐ Bone Pain
- ☐ Disc Problems
- ☐ Fractures
- ☐ Gout
- ☐ Hernia
- ☐ Joint Pain or Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Rheumatoid
- ☐ Scoliosis

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GENERAL SYSTEMS REVIEW

NEUROLOGICAL

- ☐ Alzheimer's
- ☐ Burning sensation
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Loss of Balance
- ☐ Memory Loss
- ☐ Muscles Weakness
- ☐ Parkinson's
- ☐ Sciatica
- ☐ Seizures
- ☐ Sensation Changes (numbness, coldness, tingling, crawling or prickling)
- ☐ Tremors

ENDOCRINE

- ☐ Cold Intolerance
- ☐ Diabetic
- ☐ Heat Intolerance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Increased Sweating
- ☐ Increased Thirst
- ☐ Increased Urine Output
- ☐ Water Retention

FEMALE REPRODUCTIVE

- ☐ Pregnant
  - ☐ NO
  - ☐ YES: Due-Date_____
- ☐ Birth Control Pills
- ☐ Frequent Periods
- ☐ Hysterectomy
- ☐ Lumps
- ☐ Menopause
- ☐ Missed Periods or Irregular Menstrual Bleeding
- ☐ Pelvic Inflammation
- ☐ PMS
- ☐ Regular Period
- ☐ Sexually Transmitted Disease

MALE REPRODUCTIVE

- ☐ Impotence
- ☐ Prostate Problems
- ☐ Pus Discharge
- ☐ Rashes
- ☐ STD
- ☐ Testicular Pain
- ☐ Trouble with Urination

PAIN OR NUMBNESS

- ☐ Ankles
- ☐ Arms
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Knees
- ☐ Legs
- ☐ Sciatica
- ☐ Shoulders
- ☐ Swollen Joints
- ☐ Tail bone

OTHER CONDITIONS

- ☐ AIDS
- ☐ Alcoholic
- ☐ Cancer
- ☐ Depression
- ☐ Gout
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Insomnia
- ☐ Multiple Sclerosis
- ☐ Recent Traumatic Event
- ☐ Steroid Therapy

FAMILY HISTORY

- ☐ Arthritis
- ☐ Auto immune condition
- ☐ Cancer
- ☐ Diabetes
- ☐ Genetic Problems
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Stroke
- ☐ Vascular Problems

CHILDHOOD CONDITIONS

Check all the conditions that you have ever had during your life:

- ☐ Allergies
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ Ear Infections
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Typhoid Fever
- ☐ Whooping Cough
- ☐ Other_____

ADDITIONAL INFORMATION

MEDICATIONS: ARE YOU ON ANY MEDICATIONS OR SUPPLEMENTS? IF YES PLEASE LIST THEM, DOSAGE AND REASON FOR MEDICATION.

SURGERIES: HAVE YOU HAD ANY PREVIOUS SURGERIES?

HAVE YOU HAD X-RAYS, MRI, ULTRASOUND, OR OTHER TESTS FOR THIS CONDITION? IF YES, SPECIFY WHICH TESTS HAVE BEEN PERFORMED.

HAVE YOU HAD ANY PREVIOUS FALLS, ACCIDENTS, OR HOSPITALIZATION?

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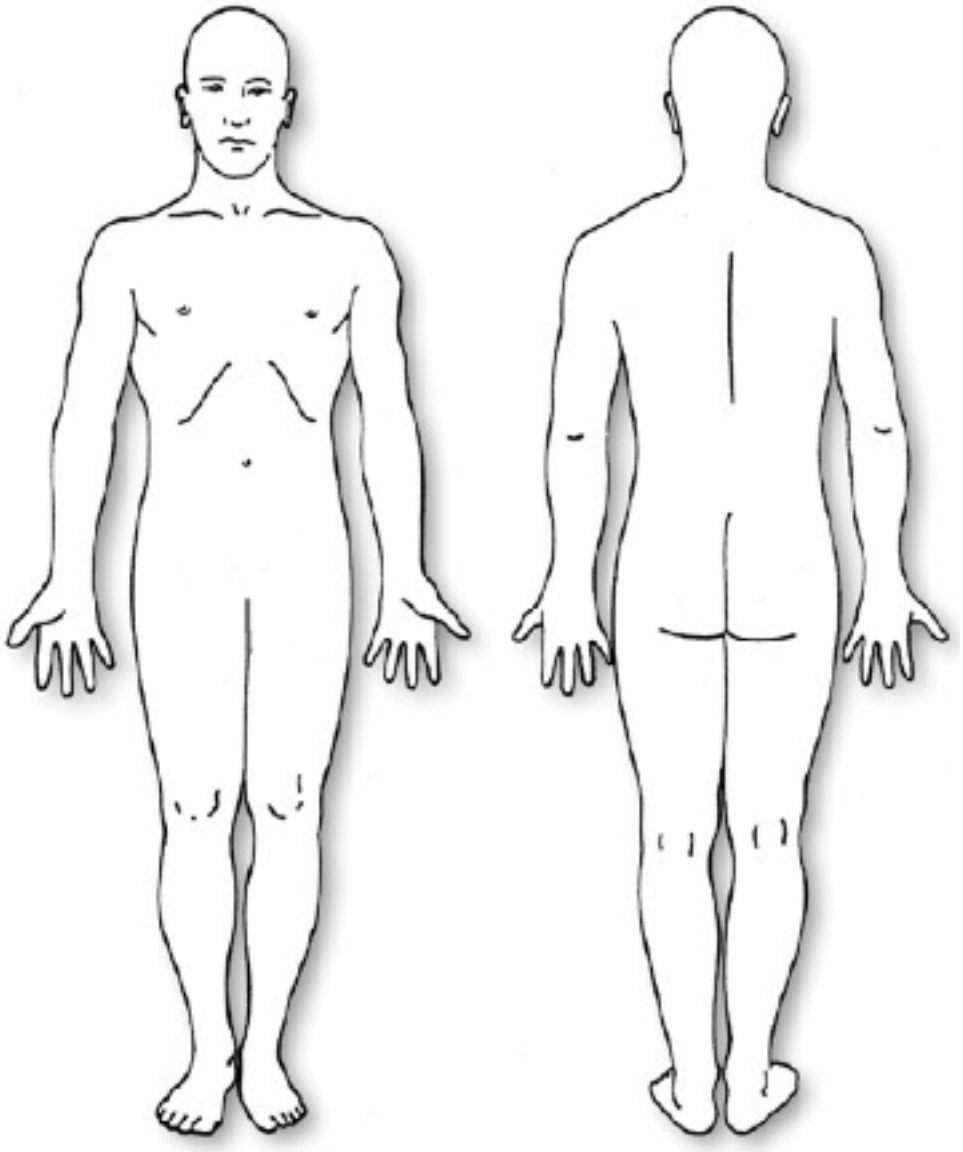
PAIN DIAGRAM



PLEASE NUMBER THE AREAS IN WHICH YOUR ARE EXPERIENCING PAIN OR DISCOMFORT

Use the following pain scale to indicate the intensity of pain in each area of the body.

PAIN SCALE	AMOUNT OF PAIN OR DISCOMFORT YOUR ARE EXPERIENCING
0	No pain or discomfort.
1, 2, 3	The pain or discomfort is an annoyance.
4, 5, 6,	The pain or discomfort interferes with activities.
7, 8, 9	The pain or discomfort prevents me from performing certain activities.
10	The pain or discomfort sends me to the emergency room.

MORE INFORMATION

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EXERCISE & LIFESTYLE

EXERCISE

DID YOUR PHYSICIAN RECOMMEND THAT YOU LOSE WEIGHT AND/OR START AN EXERCISE PROGRAM?

- ☐ Yes
- ☐ No

DO YOU EXPERIENCE CHEST PAIN WITH MILD EXERTION?

- ☐ Yes
- ☐ No

DO YOU EXPERIENCE UNUSUAL FATIGUE OR SHORTNESS OF BREATH DURING USUAL ACTIVITIES?

- ☐ Yes
- ☐ No

DO YOU EXPERIENCE DIZZINESS, FAINTING OR BLACKOUTS WITH MILD EXERTION?

- ☐ Yes
- ☐ No

HAVE YOU EXPERIENCED LEG PAIN UPON EXERTION?

- ☐ Yes
- ☐ No

HOW MANY DAYS PER WEEK ARE YOU EXERCISING?

- ☐ None.
- ☐ 1-2 days per week.
- ☐ 3-4 days per week.
- ☐ 5 or more days per week.

DO YOU DO CARDIOVASCULAR EXERCISE ON A REGULAR BASIS?

- ☐ Yes: How many times a week? _____
- ☐ No

DO YOU PERFORM STRETCHING EXERCISES ON A REGULAR BASIS?

- ☐ Yes: How many times a week? _____
- ☐ No

DO YOU LIFT WEIGHTS OR ARE YOU INVOLVED IN WEIGHT TRAINING ON A REGULAR BASIS?

- ☐ Yes
- ☐ No

SLEEP

CHECKMARK HOURS OF SLEEP PER NIGHT

2 - 4 hrs ☐ | 4 - 6 hrs ☐ | 6 - 8 hrs ☐ | 8 - 10 hrs ☐ | 12+ hrs ☐

DOES YOUR CHIEF COMPLAINT AFFECT YOUR SLEEP

- ☐ Yes
- ☐ No

HOW WOULD YOU RATE YOUR SLEEP QUALITY

- ☐ Very good
- ☐ Good
- ☐ Average
- ☐ Poor
- ☐ Very Poor

DIET

DO YOU FOLLOW A PARTICULAR DIET?

- ☐ Yes
- ☐ No

SMOKING

DO YOU CURRENTLY SMOKE?

- ☐ Yes
- ☐ No

STRESS

Stress is defined as your individual response to environmental demands or pressures (it could mean just being constantly busy with no down time).

HOW WOULD YOU RATE YOUR CURRENT LEVEL OF STRESS?

- ☐ Extreme stress
- ☐ High stress
- ☐ Moderate stress
- ☐ Low stress

IS THIS A PARTICULARLY STRESSFUL TIME IN YOUR LIFE?

- ☐ Yes
- ☐ No

TREATMENT EXPECTATIONS

WHAT WOULD YOU LIKE TO ACHIEVE BY COMING TO KINETIC HEALTH?

BEFORE WE BEGIN TREATMENT, DO YOU HAVE ANY CONCERNS OR QUESTIONS THAT YOU WOULD LIKE US TO ADDRESS ABOUT PROCEDURES, TECHNIQUES USED, OUR PRACTITIONERS, OR ANY OTHER QUESTIONS YOU WOULD LIKE TO HAVE ANSWERED?

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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.

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- **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

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Canadian Chiropractic Protective Association

Informed Consent For Acupuncture Care

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits
Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks
The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy
The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives
Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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 read this form and 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 acupuncture treatment as proposed to me.

Name (Please Print)	Signature of Patient (or legal guardian)	Date
Signature of Chiropractor		Date

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CLINIC INFORMATION

FEE SCHEDULE

- For information about specific fees, please phone our clinic at **403-241-3772**.
- Payment is due upon services being rendered. We kindly accept cash, debit card, MasterCard, and Visa.
- In ALL Cases: Patients are responsible for any payments that are not reimbursed by their insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

EXTENDED HEALTH INSURANCE

(We Submit Claims from Most Health Policies)

Both TELUS Health and BlueCross Health Care now offer a secure system that links us directly to your health care insurance, and allows us to submit your treatment claims directly to your insurance company. We, at Kinetic Health, are happy to submit insurance claims on your behalf - immediately after your payment has been processed by Kinetic Health.

All we need from you is some basic information, along with your authorization, so that we can set up the Direct Claims Submissions on your behalf. Here is the simple process:

1. Provide your insurance information to Kinetic Health.
2. Sign to authorize and allow Kinetic Health to submit a claim on your behalf.
3. Immediately after your treatment, pay for your treatment at the front desk.
4. We submit your claims information directly to your insurance company via a secure system.
5. Within one to three days (in most cases) your insurance company will either mail you a cheque, or deposit the claim amount directly into your bank account (depending on the arrangements you have made with your insurance company).

The amount of reimbursement you receive is dependent on your insurance coverage. Many insurance plans cover a set amount per year for Chiropractic and Massage treatments, while others cover a percentage of treatment (80% to 100% of treatment costs). It is well worth registering for this process, as the claim is quickly processed, and the money is soon back in your pocket!

MOTOR VEHICLE ACCIDENT CASES

Kinetic Health accepts MVA cases. Please be sure to notify the staff at Kinetic Health in advance if your claim is to be processed through MVA insurance.

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