THRIVE
Chiropractic & Wellness Centre

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone (cell): _____ Email: _____

Male/Female/Other: _____ Preferred Pronoun: _____

Alberta Health Care #: _____

*Please be advised that personal health care numbers are collected in accordance with the Alberta Health Act. Numbers are protected and used solely for the purposes of diagnosis, treatment, and referral. Alberta Health Care currently does not make payments for any portion of treatment offered at Thrive Chiropractic & Wellness Centre.

Emergency Contact Name: _____ Phone: _____

Parent Contact (if patient is <18 years of age): _____

Who can we thank for referring you to our office? _____

If you were not referred by a friend or family, how did you hear about our office? _____

Stress Level (0=No stress/10=The highest level of stress you've ever experienced)

_____

Lifestyle (exercise, sports, leisure activities, caffeine intake, alcohol/drug use, smoking)

_____

_____

_____

Current symptoms/concerns/comments about overall health or wellbeing

_____

_____

_____

Current treatments/bodywork/medication/supplements

_____

_____

_____

Past treatments/bodywork/medicine/supplements

_____

_____

_____

Medical History (include significant family history)

_____
_____
_____

Surgical/Dental History

_____
_____
_____

Accident/Fall/Broken Bone/Head Injury

_____
_____
_____

Emotional/Stressful Situation History

_____
_____
_____

Pregnant/Trying to Conceive/Birth History

_____
_____
_____

What do you know about your own birth?

_____
_____
_____

Reason for exploring BCST/Goals/Expectations

_____
_____
_____

BCST Informed Consent

By signing below, I hereby voluntarily consent to Biodynamic Craniosacral Therapy (BCST) including assessments and treatments by the therapist, Angela Dechaine.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that Craniosacral Therapists are not primary care providers. I clearly understand that BCST is not a substitute for a medical examination, medical treatment or medication.

I acknowledge that no assurance or guarantee has been provided to me as to the results of a therapy treatment session or series of sessions. I acknowledge that with any treatment there can be risks and those have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical and life conditions. I have disclosed to the therapist all of those medical and life conditions affecting me. It is my responsibility to keep the therapist updated on my medical history and any life conditions that may affect my treatment.

The information I have provided is true and complete to the best of my knowledge. I have read the above noted consent and I have had the opportunity to question the contents and the therapy. By signing this form, I confirm my consent to treatment today and include consent for additional treatment proposed by my therapist. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____
(PATIENT SIGNATURE)

_____
(DATE)

_____
(PRACTITIONER SIGNATURE)

_____
(DATE)

We understand circumstances arise, however, please note a fee of 50% of the scheduled BCST fee will be applied for multiple missed or cancelled appointments without 24 hours notice.

_____
Initial