ACTIVECARE CHIROPRACTIC

Dr. Moe Gebara DC
11704 Jasper Avenue
Edmonton, AB T5K 0N3
Phone: 780-482-7617
Fax: 780-482-3795

Patient Information

Today's Date: _____ Gender: ☐Male ☐ Female

Full Name: _____ Preferred Name: _____

Address: _____ Postal Code: _____ City: _____ Prov: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____ ☐ *check this box to opt out of receiving emails such as reminder emails, birthday emails etc.*

How would you like to be reminded of appointments: ☐ Phone Call ☐ Email ☐ SMS (Cellular provider) _____

Age:____ Birthdate: (DD)____/ (MM)_____ / (YY)_____ Alberta Health Care Number_____

Marital Status:_____Occupation:_____Employer: _____

Emergency Contact:_____Relationship:_____Phone No: _____

Is this a WCB injury: ☐ No ☐Yes Are your injuries related to a Motor Vehicle Accident? ☐ No ☐ Yes

If yes, when did the accident occur? _____

Medical Information

Family Medical Doctor's Name:_____Clinic: _____

Date of Last MD Visit:_____Reason: _____

What therapy have you previously received? ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physiotherapy

How Did You Find Us?

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Walk by

☐ Other: _____ Whom may we thank for this referral? _____

Financial Policy

As of July 1, 2009 Alberta Health Care no longer covers any portion of chiropractic. Check your extended health care plan to see if you have coverage. **We ask that all patients pay on the date of service.**

		CONSULTATION/	EXAM + ADJUSTMENT	=Total
First visit	Adults	$60	+$45	= $105
	Seniors & Students Discount	$50	+$37	= $87
	Children 15 & under Discount	$30	+$20	= $50

		ADJUSTMENT		
Regular Visits	Adult	$45	**Laser Therapy**	$25
	Seniors & Students	$37	**Shockwave Therapy**	$75
	Children 15 & under	$20	**Spinal Decompression**	$75

Re-Exam after 2.5 years or at Dr.'s discretion $30

Prices are subject to change without notice.

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Direct Billing Authorization

CARDHOLDER INFORMATION

Employee Name: _____

D.O.B. (mm/dd/yy): _____ Company: _____

I, _____, authorize **ActiveCare Chiropractic Clinic** to direct bill my health benefits plan as per the information indicated above.

I also authorize **ActiveCare Chiropractic Clinic** to inquire on the details regarding my health benefits as they apply to Chiropractic, Massage Therapy, & Custom Orthotics coverage.

_____ _____
Name of Patient Signature

_____
Date

Please make all cheques payable to ACTIVECARE CHIROPRACTIC

PLEASE PAY PROVIDER

Purpose of Visit?

What is your main health concern or complaint? _____

When and how did your symptoms first begin? _____

Have you had this before? ☐ No ☐ Yes ; Who did you see for treatment? _____

Is it getting: ☐ Worse ☐ Better ☐ Not Changing

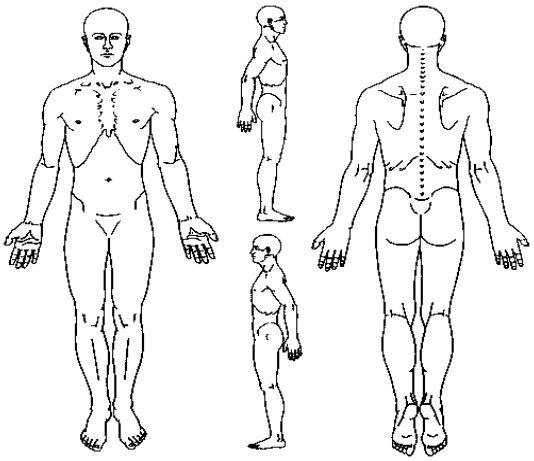
What do you hope to gain from your treatment here?

☐ **Resolve Pain:** Get me moving pain-free

☐ **Optimize Recovery:** Get me moving pain-free and provide guidance and rehabilitation to restore normal function

☐ **Improve Overall Health:** Get me moving pain-free, provide guidance and rehabilitation to restore normal function and help me be proactive in my health and wellness

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain:
S sharp **D** dull **A** achy **H** hot **C** cold **N** numb/tingling
DB deep and boring **V** variable

Please rate your pain from **0 -10** (0 is LEAST and 10 is WORST): _____

When do you feel the pain? ☐ Constantly ☐ Intermittently ☐ At Night ☐ In the Morning

Does the pain radiate down your legs or arms? ☐ No ☐ Yes

What activities are you having problems with?

☐ Balance ☐ Gripping ☐ Lifting ☐ Reaching ☐ Standing
☐ Bending ☐ Housework ☐ Pulling ☐ Sitting ☐ Travelling
☐ Fatigue ☐ Kneeling ☐ Pushing ☐ Sleeping ☐ Walking ☐ Other _____

What relieves your pain?

☐ Rest ☐ Ice ☐ Massage ☐ Other: _____
☐ Movement ☐ Heat ☐ Medication: _____

Have you seen anyone else for this condition? ☐ No ☐ Yes: Who have you seen? _____

Have you had any imaging for this condition: ☐X-Ray ☐ CT ☐ MRI ☐ Ultrasound Date: _____

Does this problem interfere with: ☐ Work ☐ Family & Social Life ☐ Sports & Hobbies ☐ Sleep

Do you have any secondary complaints? _____

Dr. _____

Health History

Please list any serious illnesses, injuries or surgeries and when they occurred: _____

_____

Please list any medication you have taken in the past 6 months: _____

Please list any allergies: _____

Do you have: High blood pressure: ☐ No ☐ Yes; High cholesterol ☐ No ☐ Yes

Current weight (lbs): _____ Weight 1 year ago: _____

Family History

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
Mother's Side:	☐	☐	☐	☐	☐	_____
Father's Side:	☐	☐	☐	☐	☐	_____

Review of Systems

Please check the box for any conditions or symptoms that you have had in the ***past six months***

General
- ❑ Fainting
- ❑ Headaches
- ❑ Fever
- ❑ Excessive Sweating
- ❑ Loss of Weight
- ❑ Night Pain
- ❑ Loss of Sleep
- ❑ Anxiety/Nervous

Neurological
- ❑ Dizziness
- ❑ Blurred Vision
- ❑ Paralysis
- ❑ Numbness/Tingling
- ❑ Clumsiness
- ❑ Nausea
- ❑ Convulsions
- ❑ Loss of Balance

Genitourinary
- ❑ Trouble Urinating
- ❑ Blood in Urine/Stool
- ❑ Kidney Infection
- ❑ Prostate Trouble
- ❑ Painful Menstruation
- ❑ Irregular/Absent Cycle
- ❑ Painful Breasts
- ❑ Menopause

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Sinus Infections
- ☐ Spitting up Blood
- ☐ Spitting up Phlegm
- ☐ Sore Throat
- ☐ Frequent Colds

Cardiovascular
- ❑ Chest Pain
- ❑ Previous Heart Attack
- ❑ Previous Stroke
- ❑ Angina
- ❑ Ankle Swelling
- ❑ Poor Circulation
- ❑ Irregular Heartbeat
- ❑ Varicose Veins

Gastrointestinal
- ❑ Poor/Excessive Appetite
- ❑ Belching/Gas
- ❑ Vomiting
- ❑ IBS
- ❑ Constipation
- ❑ Diarrhea
- ❑ Crohn's
- ❑ Heartburn

Muscle & Joint
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Shoulder/Arm Pain
- ❑ Elbow Pain
- ❑ Knee/Leg Pain
- ❑ Hip/Groin Pain
- ❑ Wrist/Hand Pain
- ❑ Ankle/Foot Pain
- ❑ TMJ/Jaw Pain
- ❑ Fibromyalgia
- ❑ Arthritis
- ❑ Disc Herniation
- ❑ Sciatica
- ❑ Gout

Eyes/Ears/Nose/Throat
- ❑ Earaches/Infection
- ❑ Ringing in Ears
- ❑ Hearing Difficulty
- ❑ Eye Pain
- ❑ Worsening Vision

Dr. _____

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