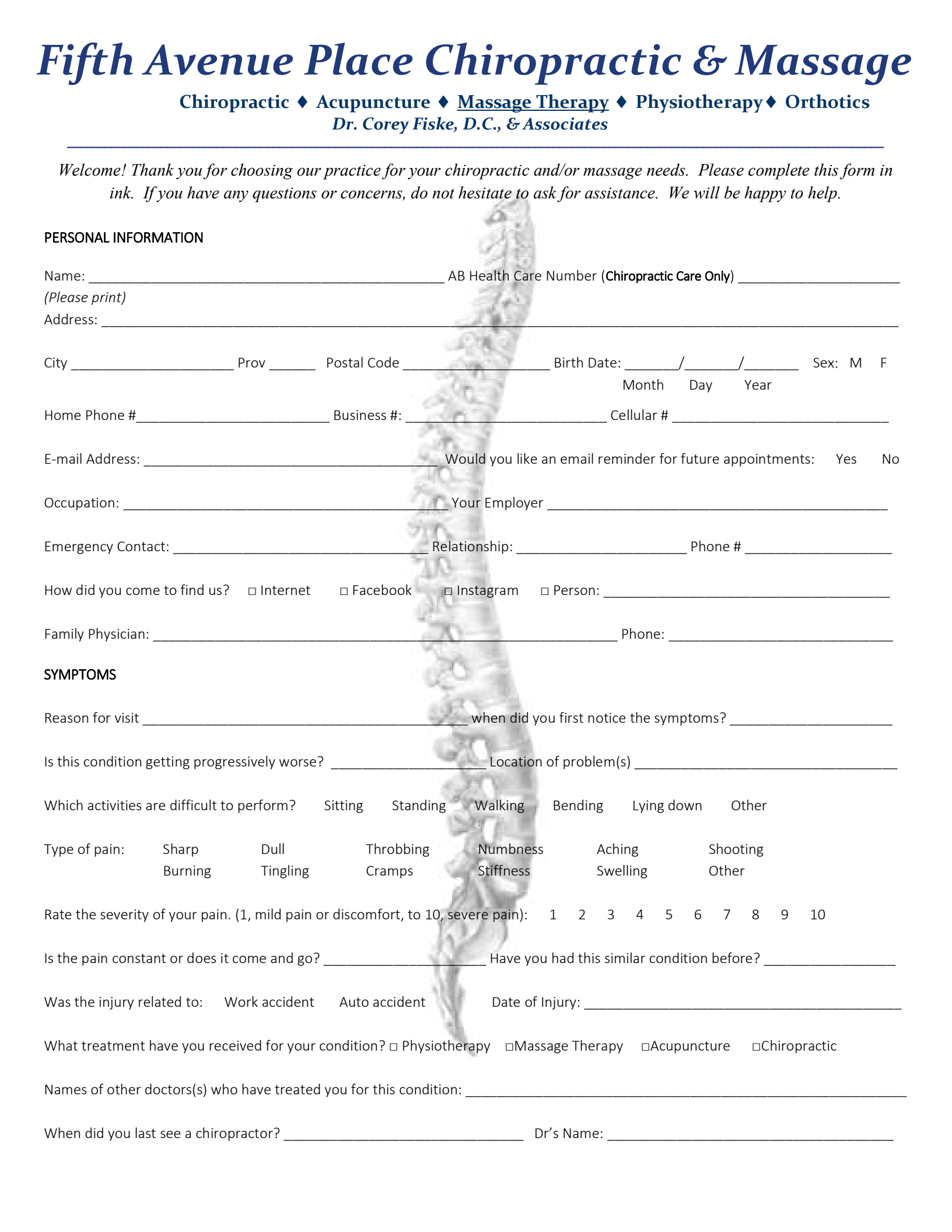
Fifth Avenue Place Chiropractic & Massage

Chiropractic ♦ Acupuncture ♦ Massage Therapy ♦ Physiotherapy ♦ Orthotics

Dr. Corey Fiske, D.C., & Associates

Welcome! Thank you for choosing our practice for your chiropractic and/or massage needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.



PERSONAL INFORMATION

Name: _____ AB Health Care Number (**Chiropractic Care Only**) _____
(Please print)
Address: _____

City _____ Prov _____ Postal Code _____ Birth Date: _____/_____/_____ Sex: M F
Month Day Year

Home Phone #_____ Business #: _____ Cellular # _____

E-mail Address: _____ Would you like an email reminder for future appointments: Yes No

Occupation: _____ Your Employer _____

Emergency Contact: _____ Relationship: _____ Phone # _____

How did you come to find us? □ Internet □ Facebook □ Instagram □ Person: _____

Family Physician: _____ Phone: _____

SYMPTOMS

Reason for visit _____ when did you first notice the symptoms? _____

Is this condition getting progressively worse? _____ Location of problem(s) _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____ Have you had this similar condition before? _____

Was the injury related to: Work accident Auto accident Date of Injury: _____

What treatment have you received for your condition? □ Physiotherapy □Massage Therapy □Acupuncture □Chiropractic

Names of other doctors(s) who have treated you for this condition: _____

When did you last see a chiropractor? _____ Dr's Name: _____

HEALTH HISTORY:

Check only those conditions which are applicable

☐ Aids/HIV	☐ Cataracts	☐ Hepatitis	☐ Mumps	☐ Stroke
☐ Alcoholism	☐ Chemical. Dependency	☐ Hernia	☐ Osteoporosis	☐ Thyroid Problems
☐ Allergies	☐ Chicken Pox	☐ Herniated Disc	☐ Pacemaker	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Parkinson's	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ High Blood Pressure	☐ Pneumonia	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Kidney Disease	☐ Polio	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Liver Disease	☐ Prostate Problems	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Measles	☐ Prosthesis	☐ Whooping Cough
☐ Breast Lump	☐ Goiter	☐ Migraines	☐ Psychiatric Care	☐ Other_____
☐ Bronchitis	☐ Gonorrhea	☐ Miscarriage	☐ Rheumatoid Arthritis	
☐ Bulimia	☐ Gout	☐ Mononucleosis	☐ Rheumatic Fever	
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Scarlet Fever	

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

DAILY HABITS

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor ☐ Computer work

Do you smoke? ☐ Yes ☐ No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a weekly basis? _____

PLEASE NOTE WE WOULD APPRECIATE 24 HOURS NOTICE TO CHANGE OR CANCEL AN APPOINTMENT. YOUR APPOINTMENT TIME IS VALUABLE AND IF YOU ARE UNABLE TO MAKE IT WE WOULD LIKE TO OFFER THAT TIME TO ANOTHER PATIENT.
WE DO CHARGE FOR MISSED APPOINTMENTS.

AUTHORIZATION

We maintain a high standard for the protection of the confidentiality and integrity of individual health information. If any identifying health information is to be disclosed to another party or we require information to be released to us for the purposes of providing ongoing care; express written consent will be obtained. If you have any questions regarding your privacy concerns, feel free to direct any inquiries to the front desk.

I have read and understand the above policies and procedures that are in place and agree to the terms.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of Patient (or parent if a minor) Date

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Informed Consent to Massage Therapy

I do hereby give consent to any and all registered massage therapists practicing at Fifth Avenue Place Chiropractic and Massage, to perform massage therapy treatments as requested. I have had an opportunity to discuss the purpose of massage therapy, and should any concerns arise at any time I will not hesitate to ask. I understand that results are not guaranteed.

I have given any and all registered massage therapists valid information regarding my health condition, to the best of my knowledge, and will not hold them responsible for further complications herein.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Dated: _____

X_____ _____

Signature of Patient (or parent if a minor) Witness

Name: Name:

(Please print) (Please print)