Fifth Avenue Place Chiropractic & Massage

Chiropractic • Acupuncture • Massage Therapy • Physiotherapy • Orthotics

Dr. Corey Fiske, DC

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 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? _____ Chiropractors Name: _____

What other services might you be interested in? _____
(Chiropractic, Physiotherapy, Shockwave, IMS, Massage Therapy, Acupuncture)

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	☐ Covid 19
☐ Bronchitis	☐ Gonorrhea	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Other _____
☐ 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.

I agree that a photocopy of this authorization shall be valid as the original.

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

Informed Consent to Acupuncture and Traditional Chinese Medicine

PLEASE READ AND INITIAL EACH SECTION BEFORE SIGNING BELOW.

Alberta acupuncture legislation states that an acupuncturist shall not undertake the care and treatment of a person unless that person has already consulted with a physician or in the case of dental pathology, a dentist about the condition for which he/she is seeking care and treatment. Therefore, please choose the applicable box confirming that you have informed the acupuncturist that

□ I have already consulted a physician regarding the condition(s) that I am seeking treatment for;

□ I agree to see a doctor regarding the condition(s) that I am seeking treatment for within 2 weeks of my first acupuncture treatment.

Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electro-acupuncture by the duly authorized doctor in the clinic. I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles. I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each treatment. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the period of the treatment, which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed. I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the abovementioned acupuncture procedures. I intend this consent form to cover the entire course of the treatment for my present and future conditions for which I seek treatment.

INITIALS_____

Traditional Chinese Medicine

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications. It is important that you inform your practitioner immediately of:

- Any disease process from which you currently suffer;
- If you are on any medications either prescribed or over-the-counter;
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding.

There are some health risks associated with treatment by Traditional Chinese Medicine. These include but aren't limited to:

- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Practitioner of any allergies you may have;
- Muscle strains and sprains, and disc injuries from spinal manipulation;
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand that my TCM practitioner will answer any questions that I have, to the best of his/her ability. I understand that results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and complications. I will rely on the practitioner to exercise judgment during the period of my treatment which s/he feels is in my best interest based on the facts which are known.

With this acknowledgement, I voluntarily consent to the treatment recommended to me by my practitioner. I intend for this consent to apply to all my present and future Traditional Chinese Medicine Care.

INITIALS_____

Cancellation Policy

IF I AM UNABLE TO ATTEND A SCHEDULED APPOINTMENT I WILL PROVIDE 24 HOURS NOTICE TO AVOID BEING CHARGED A MISSED APPOINTMENT FEE OF 100%. I AGREE TO PAY MY FULL AMOUNT AT THE TIME OF EACH VISIT OR TREATMENT, INCLUDING FEES FOR SERVICE AND ANY GOODS PURCHASED.

PATIENT SIGNATURE (or parent if a minor): _____ **Date:** _____

WITNESS SIGNATURE: _____ **Date:** _____