Fifth Avenue Place Chiropractic & Massage Therapy

Chiropractic · Massage Therapy · Acupuncture · Physiotherapy · Orthotics

Welcome! Thank you for choosing our practice for your health related needs. Please complete this form in ink.

Name: _____ AB Health Care Number: _____

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: _____

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

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

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/vape? □ Yes □ No

HEALTH HISTORY:

Check only those conditions which are applicable (past and present):

☐ 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: _____

COMMUNICATION CONSENT

I authorize Fifth Avenue Place Chiropractic & Massage Therapy to contact me using electronic communication (email, text, phone) for:

- Appointment Reminders
- Treatment Follow Ups
- Health Related Updates and/or Questions
- Scheduling or Billing Inquiries

I understand that electronic communications may not be encrypted, and while reasonable safeguards are in place, there is a potential risk of unauthorized access. I may withdraw my consent at any time by providing written notice.

X_____ _____

Signature of Patient (or parent if a minor) Date

PRIVACY ACKNOWLEDGEMENT: Fifth Avenue Place Chiropractic and Massage Therapy complies with Alberta's *Personal Information Protection Act (PIPA).* We are committed to protecting your personal health information and using it only for appropriate healthcare and administrative purposes. 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 understood 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

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.

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CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

● Temporary discomfort or worsening of symptoms – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.

● Skin irritation or burn – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.

● Sprain or strain – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.

● Rib fracture – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.

● Disc injury or aggravation – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.

● Stroke – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____

Patient Name (print)

_____ _____ _____

Parent/Guardian Signature Date Chiropractor Signature