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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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)