Ascent Integrative Health*
Chiropractic Intake Form

Welcome to Ascent! We are honoured to partner in your health goals. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly before your first appointment. All information is strictly confidential.

Contact Info: T: 403.262.1121 F: 403.262.1371 E: info@ascenthealth.ca

Patient Information

Today's Date: _____ Gender: _____

Full Name: _____ Preferred Name: _____

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

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____ ☐ I would like to receive E-mails for appointment reminders, clinic updates, and e-newsletter *(please note you can opt-out at any time)*

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

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

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

If Yes, please request the appropriate form from the front staff.

Medical Information

Family Medical Doctor's Name: _____ Clinic: _____

Date of Last MD Visit: _____ Reason: _____

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

* Communication between healthcare providers can greatly improve the quality and safety of patient care.

If necessary, do you consent to allow your health provider at Ascent to contact your medical doctor? ☐ No ☐ Yes

Extended Health Benefits

Do you have a private insurance plan ☐ No ☐ Yes(Self) ☐ Yes(Spouse)

Name of primary policy holder (Spouse/Parent): _____

We are able to direct bill for most major benefit providers.

Benefit provider: _____

Policy No. _____ Member ID: _____ Group No: (*ABC Only): _____

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?

Purpose of Visit?

What is your main health concern or complaint? _____

When did the symptoms first begin? _____

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

Is it getting: ☐ Worse ☐ Better ☐ Not Changing

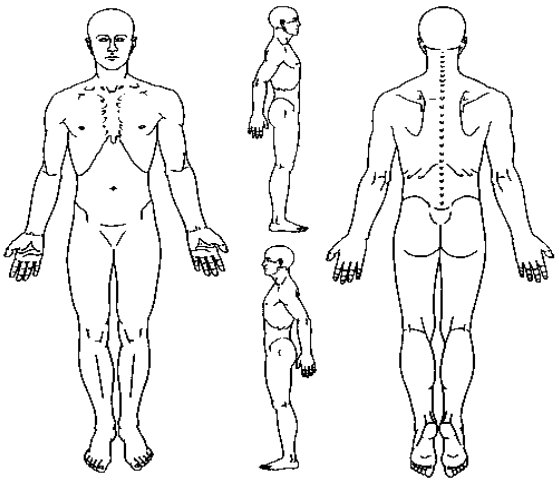
What do you hope to gain from your treatment here?

☐ **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 note that this section cannot be filled out on the computer. Please complete in ink once the form has been printed.

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? _____

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: _____

Are you currently pregnant or recently been pregnant? _____

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

Lifestyle

Are you currently a smoker? ☐ No ☐ Yes; How many per day?:_____ For how many years? _____

Did you smoke previously? ☐ No ☐ Yes; How long ago?: _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes; How often? ☐ Daily ☐ Weekly ☐ Infrequently

Do you drink coffee? ☐ No ☐ Yes; How often? ☐ Daily ☐ Weekly ☐ Infrequently

Do you use recreational drugs? ☐ No ☐ Yes; How often? ☐ Daily ☐ Weekly ☐ Infrequently

What would you say about your diet? ☐ Needs significant improvement ☐ Okay for now ☐ Very healthy

Do you exercise regularly? ☐ No ☐ Yes; Type & Frequency: _____

What are your stress levels? ☐ Extreme ☐ High ☐ Moderate ☐ Low ☐ Very Minimal

Are you interested in improving your diet &/or losing weight? ☐ Yes, Both ☐ Yes, Diet ☐ Yes, Weight ☐ N

Cancellation Policy & Fee Schedule

I realize that my health insurance may not cover 100% of the recognized fee schedule and that I am responsible for any incurred appointment fees. A **minimum of 24 hours notice** is required for appointment changes and/or cancellations. If less than adequate notice is provided, or if you miss your appointment, Ascent reserves the right to charge your account the full amount of the scheduled appointment.

☐ I agree to the terms ☐ I do not agree to the terms Signature: _____

Confidentiality & Disclosure of Personal Information

Ascent Integrative Health (ASCENT) understands the importance of protecting personal information. We are committed to the collection, use, and disclosure of this information in a responsible way. Staff members who come into contact with your personal information are trained in the appropriate use and protection of your information.

By signing the consent section of this form, you agree to give consent to the collection use, and disclosure of your personal information for the purposes of:

- Delivering safe & effective patient care
- Enabling us to contact you & process payments
- Communicating with other healthcare providers
- Completing & submitting claims on your behalf to third party payers
- Complying with legal and regulatory requirements
- Filling out relevant requisition forms
- Complying with legal and regulatory requirements

I agree that ASCENT can collect, use, and disclose my personal information as set out above in the clinic's privacy code.

Signature: _____ Printed Name: _____

ASCENT
INTEGRATIVE HEALTH

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

ASCENT
INTEGRATIVE HEALTH

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits
Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks
The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy
The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives
Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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 read this form and 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 acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date