# Balanced Health and Sports Therapy

**Chiro ● Physio ● Massage**

**Chiropractic Intake Form**

**Personal Information:** Date: _____

First Name: _____ Last Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Telephone: Home:_____ Cell: _____Work:_____

E-mail: _____ Alberta Health Care Number:_____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Sex: _____

Occupation: _____

Please check what type of reminder you would prefer: Email Reminder: ☐ Phone Call: ☐ None: ☐

Emergency Contact Information: Name: _____ Phone: _____

How did you hear about the Balanced Health and Sports Therapy? _____

Will your care be covered by? **Private ins**: ☐ Yes ☐ No **If Yes Who**: _____

**Motor Vehicle Accident:** ☐ Yes ☐ No **WCB:** ☐ Yes ☐ No **Veteran Affairs:** ☐ Yes ☐ No

## PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

**Please note our cancellation policy: If less than 24 hours' notice is given to cancel your appointment, your account will be charged the full price of the appointment.**

**I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.**

_____ _____

**SIGNATURE of Patient (or parent/guardian)** **DATE**

Please complete the questionnaire. Your answers will help determine if Chiropractic treatments can help you. If we do not believe your condition will respond satisfactory, we will not accept your case.

**Health Information:**

Reason for consulting Balanced Health & Sports Therapy: _____

Have you ever had Chiropractic Care: ☐ Yes ☐ No When: _____

By whom: _____ for what condition: _____

List all surgical operations and years: _____

List all the medication(s) you are currently taking:_____

_____

_____

List all the vitamin(s) and or supplement(s) you are currently taking:_____

_____

_____

Have you ever been in an auto accident: ☐ Yes ☐ No When: _____

Accident details: _____

Have you had any other personal injuries or accidents: _____

Have you had any x-rays: ☐ Yes ☐ No Where:_____ When:_____

Do you sleep well: ☐ Yes ☐ No What position do you sleep in:_____

Do you exercise regularly: ☐ Yes ☐ No, if yes explain

_____

_____

Do you have any diagnosed medical conditions? ☐ Yes ☐ No, if yes explain

_____

_____

Date of last physical examination:_____ Medical Doctor:_____

Date of last dental examination:_____ Dentist:_____

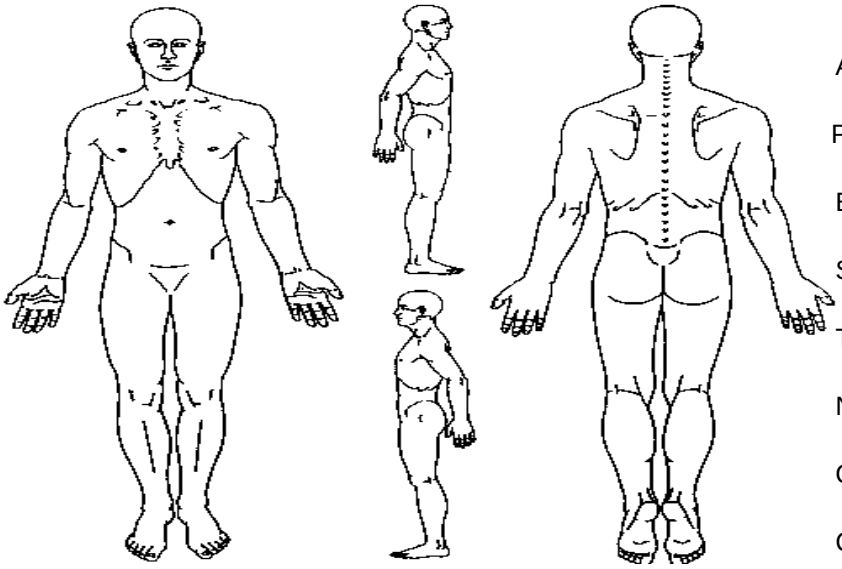
Describe what work related activities you do on a daily basis: (ex: lifting, typing, prolonged standing)

_____

# Balanced Health and Sports Therapy

**Chiro ● Physio ● Massage**

**MARK THE AREA(S) OF THE DIAGRAM WHERE YOU FEEL THE DESCRIBED SENSATION.**



ACHING: **A**

PINS/NEEDLE: **P**

BURNING: **B**

STABBING: **S**

TIGHT/STIFF: **T**

NUMBNESS: **N**

OTHER: _____+ + + + +

COMMENTS _____

**FAMILY HEALTH - Many health problems are a result of hereditary spinal weakness and have a tendency to occur in families. Please fill in the following chart.**

| Family | Age | Health Problems |
|---|---|---|
| Father | | |
| Mother | | |
| Brother / Sister | | |
| Children | | |

**Health Conditions**:
Please **circle** any conditions that are presently causing you a problem. Please **check** those conditions which have been a problem in the past.

**General Symptoms**
Fever
Sweats
Fainting
Loss of sleep
Fatigue
Nervousness
Loss of weight

**Respiratory**
Chronic Cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

**Genitourinary**
Frequent urination
Painful urination
Blood in urine
Pus in urine
Prostate trouble
Urine control

**Neurological**
Visual disturbance
Dizziness
Convulsions
Headache
Mood changes
Coordination

**Cardiovascular**
Rapid beating heart
Slow beating
High blood pressure
Low blood pressure
Pain over heart
Hardening of arteries
Poor circulation

**Gastrointestinal**
Poor appetite
Difficult digestion
Nausea
Vomiting
Vomiting blood
Constipation
Colitis

**E.E.N.T**
Eye pain
Deafness
Nosebleeds
Hoarseness
Asthma
Sinus infection
Enlarged glands

**Muscle & Joint**
Stiff neck
Backache
Neck pain
Swollen joints
Foot trouble
Pain in shoulders

**For Women Only**
Painful menstruation
Hot flashes
Irregular Cycle
Cramps or backache
Vaginal discharge
Lumps in breast
Menopause

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898

**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 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 MEETWITH 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

# Graston Technique® Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning Graston Technique, and sign below. If you have any questions, please speak with your clinician.

| | | |
|---|---|---|
| 1. Do you bruise easily? | Yes | No |
| 2. Do you bleed for a long period of time after you cut yourself | Yes | No |
| 3. Are you taking blood thinners or anticoagulants? | Yes | No |
| 4. Do you take aspirin on a regular basis? | Yes | No |
| 5. Do you take cortisone on a regular basis? | Yes | No |
| 6. Have you ever had inflamed veins or blood clots? | Yes | No |
| 7. Do you have surgical implants in your body? | Yes | No |
| 8. Do you have diabetes or kidney disease? | Yes | No |
| 9. Do you currently have any infections? | Yes | No |
| 10. Do you have uncontrolled high blood pressure? | Yes | No |

Graston Technique (GT) is an instrument-assisted variation of traditional cross fiber or transverse friction massage. The GT instruments consist of six stainless steel tools of various sizes and contours. GT is a form of treatment used to “break up” or “soften” scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

Graston Technique is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

Graston Technique has several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. Graston Technique Instrument Assisted Soft-Tissue Manipulation.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition, high weight exercises.
6. Ice therapy.
7. Stretching/rehabilitation exercise.

All components of Graston Technique have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Patient Name: _____ Date: _____

Signature of Patient (or Parent/Guardian): _____

# 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.

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

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

_____ Date: _____20____
Signature of Chiropractor

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898

# Chiropractic and Physiotherapy Authorization to obtain medical records.

To: (record holder – completed by office)

_____

I, _____, do unconditionally authorize you to release to BALANCED HEALTH AND SPORTS THERAPY or anyone they shall in writing designate, any and all information they may so require in relation to my health, including, but without limitation all plain film radiographs including x-ray films, radiology reports, clinical and progress notes, nurses notes, reports on diagnostic test, secondary assessment, chiropractic and medical opinions and/or any other knowledge, information or data which you possess or have power to deliver, and for so doing kindly allow this to be your complete and sufficient authority.

_____

In consideration for your release of the information to my doctor, I hereby waive any patient privilege I may have regarding secrecy of chiropractic and medical information and I do release and discharge you and your assigns and/or successors of and from all claims for any damages resulting from the release of such information.

Date: _____

Signature: _____
Patient (or parent/guardian)

Witness: _____
Signature

Witness: _____
Name

**Informed Consent & Questionnaire for Laser Therapy**

Please answer the following questions and read the statements below concerning High Power Class IV K-Laser® (Infrared) Therapy. If you have any questions, please speak with your clinician.

| | | |
|---|---|---|
| 1. Is there any chance that you may be pregnant? | Yes | No |
| 2. Do you currently have (or have a history of) cancer? | Yes | No |
| 3. Do you have a family history of cancer? | Yes | No |
| Please list: _____ | | |
| 4. Do you have a pacemaker or electronic implant? | Yes | No |
| 5. Are you taking any blood thinners (ex. Aspirin)? | Yes | No |
| 6. Do you have very light sensitive skin (Photosensitive)? | Yes | No |
| 7. Do you currently have any infections/fever? | Yes | No |
| 8. Do you have Heart or Kidney disease? | Yes | No |
| 9. Are you taking any of the following medications (please circle): | Yes | No |

Antihistamine, Coal Tar and derivatives, Antifungals, Contraceptives (birth control), Phenothiazines, Psoralens, Corticosteroids, Cortisone Sulfonamides, Sulfonylureas, Thiazide Diuretics (water pills), Tetracyclines, Tricyclic Antidepressants, High dose Vitamin A (ie. Accutane), Immunosuppressant drugs

Laser Therapy is a safe and effective therapy that is Health Canada cleared for the treatment of muscle and joint-related pain. Laser promotes the relaxation of spasm spasm/tension and promotes both increased tissues energy production and vasodilatation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks; however, your specific results may vary. Adverse effects from laser therapy may occur from multiple sources, in most cases involving a hypersensitivity to light, preexisting medical condition, thermal effects, excessive pressure from the treatment probe and laser over-stimulation. Laser therapy can cause serious damage to the eye, therefore it is very important to wear the protective glasses that will be provided at all times during treatment. Although rare, the most common adverse effects to laser therapy are:

1. Temporary increase in pain during laser application
2. Temporary increase in pain in the following day after laser therapy
3. Mild bruising
4. Temporary dizziness
5. Reactions when photosensitizing drugs are used with laser therapy

Your clinician has been thoroughly trained and certified to identify and minimize risk of any adverse reaction.

I have read and understand the potential risk associated with Laser Therapy and agree to the treatment program outlined by my clinician.

Date Signed_____ Patient Name_____Patient Signature _____

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898