Welcome to All Sport Health & Performance!

Here is what you can expect on your first visit:

1. **Confidential Patient Health Records:** All new patients are requested to thoroughly complete the following pages.

2. **Consultation & Examination:** You will receive a comprehensive consultation and examination to discuss your health problems and to determine if chiropractic care is appropriate for your condition. The examination is an in-depth assessment of your musculoskeletal and nervous systems and may incorporate the following testing: postural analysis, range of motion, muscle and nerve testing, gait analysis, and spinal/extremity assessment.

3. **Report of Findings:** Following your examination, you will be informed of your results and recommended a treatment plan.

4. **Treatment:** Once finished with the examination and all appropriate studies, patients will generally be provided with their first treatment during this same visit. This may include spinal adjustments, physical therapies, and/or specialized soft-tissue therapies including Active Release Technique or Graston Technique. All procedures will be described in detail and your consent will always be obtained prior to any treatment that we may provide. **If you have questions or are at all uncomfortable with any procedure we have discussed voice your concerns and our doctors will develop a suitable treatment plan that fits your needs and comfort level.** Examination, report of findings and treatment generally take about 30 minutes.

5. **Additional Testing:** If indicated, the doctor will advise you as to the need of additional procedures such as imaging, referrals or patient co-management.

As a courtesy to other patients, All Sport Health & Performance requires 24 hours notice if you are unable to keep your appointment. This enables one who needs care to receive it. Appointments cancelled with less than 24 hours notice will be charged a $25.00 fee.

_____

Please sign to confirm you have read the above and agree to the terms

ALLSPORT HEALTH & PERFORMANCE

Date: _____

PATIENT INFORMATION

Paitent's Last Name: _____First Name: _____
Home Address: _____City: _____ Postal Code: _____
Date of Birth: D____/M____/ Y____Age:_____Gender: ☐ Male ☐ Female
Occupation: _____Employer:_____
Business Phone: _____
Marital Status: _____Name of Spouse: _____
No. of Children? _____
Who is legally responsible for this account? _____
By Whom were you referred?_____

CONTACT INFORMATION

Home Phone: _____
Cell Phone: _____
Email: _____

Emergency Contact

Name: _____
Phone Number: _____

PROVINCIAL HEALTH CARE INSURANCE PLAN

Alberta Healthcare #: _____
Other Health Insurance:
_____
_____

CHIROPRACTIC HEALTH INFORMATION

(Please circle your answer to each question. If yes, please explain)

Have you had previous chiropractic care? ☐ no ☐ yes Doctor: _____
What were you treated for? _____
How long has it been since you felt good? _____
Please list any surgical operations and years performed: _____
_____
Name of Medical Doctor: _____
Are you currently Taking: ☐ birth control ☐heart medication ☐insulin ☐ muscle relaxants
☐ Nerve Pills ☐pain pills ☐tranquilizers ☐vitamins _____
Age of Mattress: _____ How do you sleep: ☐ side ☐ back ☐ stomach ☐ combination
Have you ever been in an auto accident? ☐ yes ☐ no Describe: _____
Have you had a personal injury or accident? (Describe): _____
Interests/Hobbies? _____

FAMILY MEDICAL HEALTH INFORMATION

(FOR A FAMILY MEMBER MARK X, FOR YOURSELF PLEASE CIRCLE)

Do you or a family member have any of the following?

☐AIDS	☐Bed Wetting	☐Epilepsy	☐Schizophrenia
☐Alcoholism	☐Cancer	☐Hyperactivity	☐Stomach Ulcers
☐Allergies	☐ Cardiovascular disease	☐Learning Disability	☐Other
☐Arthritis	☐Depression	☐Lumbago	
☐Asthma	☐Diabetes	☐Multiple Sclerosis	

CURRENT PATIENT CONDITION

What is your major complaint at present time? _____

_____

When and how did your symptoms begin? _____

Have you had this condition before? If yes, when? _____

Is your condition getting progressively: ☐worse ☐better ☐staying the same

What makes it better? _____ What makes it worse? _____

Are your symptoms worse in the: ☐morning ☐daytime ☐evening ☐ constant

How does it feel? ☐ Burning ☐Sharp ☐Stiff ☐Ache ☐Numbness ☐Shooting ☐Tingling Other?_____

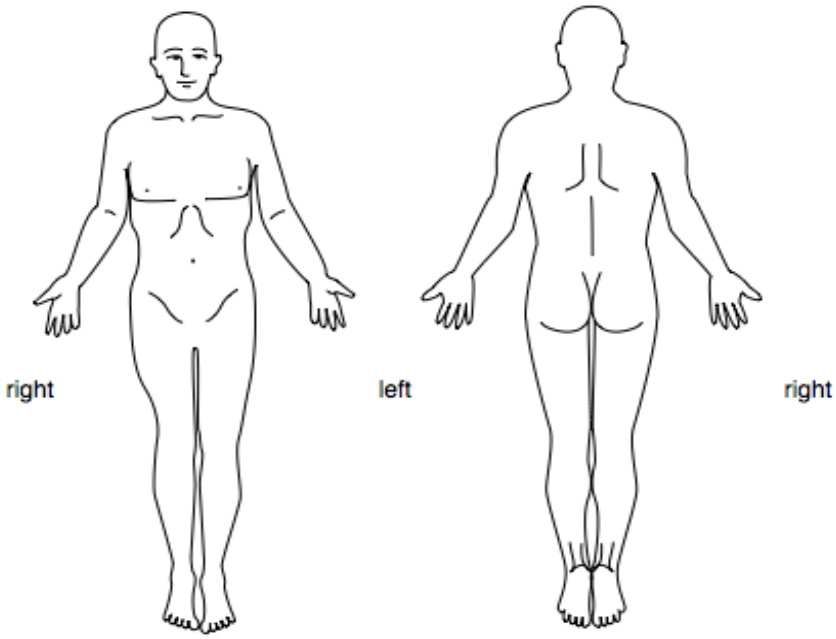
Is this condition interfering with your ☐ work ☐ sleep ☐ daily routine ☐other_____

How long have you had this condition? _____

Is the condition a result of a motor vehicle accident or workers compensation injury? _____

On the picture below, use the indicated marks to show areas where you have experienced the following symptoms:

PAIN: XXXX **NUMBNESS: ////** **TINGLING: 0000**



Additional Coments:

_____

_____

_____

_____

_____

For the dominant area of pain, how would you judge that pain on a scale of zero-to-ten (where zero is no pain and 10 is the worst pain imaginable). Place an "x" on the corresponding value on these scales:

ON THE AVERAGE: _____

0 **10**

AT IT'S WORST: _____