120, 817 - 19th St NE Calgary, AB T2E 4X5 | 403.520.5265 | getadjusted@brostchiro.com

Completion of this confidential form is required by all Brost Chiropractic & Wellness Centre patients on their first visit so the practitioners providing your care are accurately informed. We also ask that you keep us up-to-date with this information as it changes, as this is part of your permanent record.

It is our clinic policy to keep all of our records completely confidential. No copy of your file shall be released unless the request is accompanied with your signed consent. All of your original records will remain at Brost Chiropractic & Wellness Centre for up to seven years from the last date seen after which time they may be shredded and destroyed.

Name: (Last) ________________________________ (First) _________________________________ (Middle) _______________________

Address: _______________________________________ City: _______________________ Province: ________ Postal Code: ___________

Alberta Health Care # ____________________________ Date of Birth: Month ________ Day ________ Year ________ ☐Male ☐ Female

Home Phone: _______________________________________ Work Phone: __________________________________ ext _____________

Cell Phone: ____ Email: ____

Preferred contact: ☐ Home ☐ Work ☐ Cell

Marital Status: ☐ single ☐ married ☐ divorced ☐ widow(er) ☐ common law Married to: __________________________________

Number of Children: ___________ Names & Ages of Children: ____

____

☐ Full-time Employed ☐ Part-time Employed ☐ Self-Employed ☐ Unemployed ☐ Retired

Occupation: ____ Employer: ____

☐ Full-time Student ☐ Part-time Student School: ____

Emergency Contact Name: _____________________________ Phone: _______________________ Relationship: ____________________

How did you hear about our office? ____

Who may we thank for referring you to this office? ____

Have you been treated by a Chiropractic Doctor before?

☐ No ☐ Yes - Chiropractor: _____________________________

Tel: ____________________ Last Appt: ____________________

X-Ray's taken ☐ No ☐ Yes - When? ______________________

Where? ____

Why did you leave care? _________________________________

____

Have you been treated by a Massage Therapist before?

☐ No ☐ Yes - Therapist: _____________________________

Tel: ____________________ Last Appt: ____________________

Medical Doctor: ____

Tel: ______________________ Last Appt: ______________________

Clinic Name/Location: ______________________________________

What is the primary reason for your visit? ____

____

Is this due to a: ☐ Automobile Accident ☐ Work-related Injury ☐ Personal Injury Case ☐ None/Other_______________________

When did your pain/symptoms begin (include date if possible) ____

The overall severity of your complaints/concerns is: ☐ N/A ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderately Severe ☐ Severe

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The overall frequency is: ☐ Occasional ☐ intermittent ☐ frequent ☐ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today?

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst Possible

If your symptoms change, when are they worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down ☐ Cold

☐ Dampness ☐Other: ____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication

Other: ____

Character of Pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Constant ☐ Intermittent

Is the pain getting ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Does the pain radiate anywhere? ☐ No ☐ Yes Where: ____

Have you had recent treatment for this condition? ☐ No ☐ Yes - Please list dates/doctors ____

____

____

Have you had the same or similar problems in the past? ☐ No ☐ Yes – please describe ____

____

Do you have any additional complaints/concerns/health problems? ☐ No ☐ Yes – please describe: _________________________________

____

Since your symptoms began, have you noticed any function changes: ☐ No ☐ Bowel ☐ Bladder ☐ Sexual

Use the following key to mark your complaints on the diagram below:

Pain = P

Numbness = N

Weakness = W

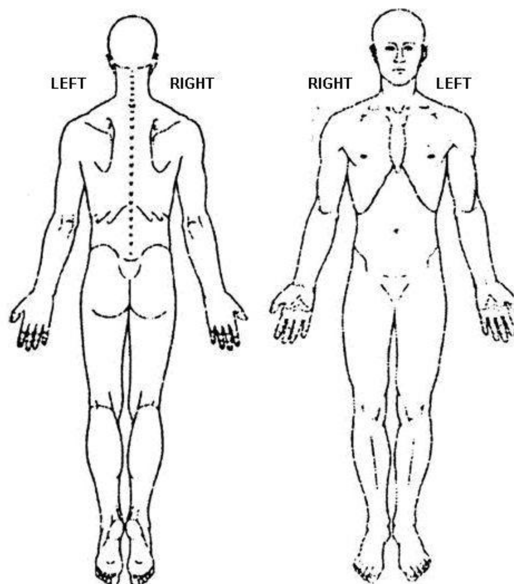
Soreness = O

Stiffness = X

Swelling = S

Burning = B

Tingling = T



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Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other: ____________________

Previous: ☐ Childhood Traumas: ____________________ ☐ Sports Injuries: ____________________

☐ Motor Vehicle Accidents: ____________________ ☐ Work Injuries: ____________________

☐ Hospitalization (other than above) : ____________________

____

Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

☐ Other (including over the counter & prescription): ____________________

____

____

Do you suffer from any other condition than the one you are now consulting us for? ____________________

____

Which of the following best describes your stress level: ☐ None ☐ Minimal ☐ Moderate ☐ Extreme

Do you smoke? ☐ No ☐ Yes – how much: ____________________

How many caffeinated drinks do you consume per day: ____________________

How many alcoholic drinks do you consume per week: ____________________

Do you have weight issues? ☐ No ☐ Yes

Do you sleep on your stomach? ☐ No ☐ Yes ☐ Sometimes

Do you carry a wallet in your back pocket? ☐ No ☐ Yes ☐ Sometimes

How often do you consume processed or prepared foods? ☐ None ☐ Occasionally ☐ Frequently ☐ Usually

Please indicate any health issues that are present in your family:

Parents: ____________________

____

Siblings: ____________________

____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes – whom? ____________________

Have your children ever had a spinal check-up? ☐ No ☐ Yes – where and when? ____________________

____

Is there anything else you would like us to know: ☐ No ☐ Yes

____

____

____

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Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of Chiropractic Care. Check any of the following you have had in the past six months:

Nervous System

☐Nervous

☐Numbness

☐Paralysis

☐Dizziness

☐Confusion / Depression

☐Fainting

☐Convulsions

☐Cold / Tingling Extremities

☐Stress

Musculo-Skeletal

☐Low Back Pain

☐Gas / Bloating After Meals

☐Pain Between Shoulders

☐Heartburn

☐Neck Pain

☐Black / Bloody Stool

☐Arm Pain

☐Colitis

☐Joint Pain / Stiffness

☐Walking Problems

☐Difficult Chewing / Clicking Jaw

☐General Stiffness

C-V-R

☐Chest Pain

☐Short Breath

☐Blood Pressure Problems

☐Irregular Heartbeat

☐Heart Problems

☐Lung Problems / Congestion

☐Varicose Veins

☐Ankle Swelling

☐Stroke

EENT

☐Vision Problems

☐Dental Problems

☐Sore Throat

☐Ear Aches

☐Hearing Difficulty

☐Stuffed Nose

Genito-Urinary

☐Bladder Trouble

☐Painful / Excessive Urination

☐Discolored Urine

Gastro-Intestinal

☐Poor / Excessive Appetite

☐Excessive Thirst

☐Frequent Nausea

☐Vomiting

☐Diarrhea

☐Constipation

☐Hemorrhoids

☐Liver Problems

☐Gall Bladder Problems

☐Abdominal Cramps

Check any of the following diseases your have had:

☐Pneumonia

☐Mumps

☐Influenza

☐Rheumatic Fever

☐Small Pox

☐Pleurisy

☐Polio

☐Chicken Pox

☐Arthritis

☐Tuberculosis

☐Diabetes

☐Epilepsy

☐Whooping Cough

☐Cancer

☐Mental Disorder

☐Anemia

☐Heart Disease

☐Lumbago

☐Measles

☐Thyroid

☐Eczema

General

☐Fatigue

☐ Allergies

☐ Loss of Sleep

☐ Fever

☐ Headaches

☐ Significant Weight Loss

Males Only

☐Prostate Issues

☐ Sexual Dysfunction

Female Only

☐ Menstrual Irregularity

☐ Menstrual Cramping

☐ Vaginal Pain / Infections

☐ Breast Pain / Lumps

When was your last period?

____

Are you Pregnant?

☐ Yes ☐ No ☐ Not sure

Lifestyle Stress Levels

☐ High

☐ Moderate

☐ Very Little

Intake

☐ Coffee

☐ Tea

☐ Alcohol

☐ Cigarettes

☐ White Sugar

☐ Drugs

Satisfaction with Diet

☐ Highly Satisfied

☐ Dissatisfied

☐ Highly Dissatisfied

Do you have a regular exercise program?

☐ Yes

☐ No

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Preventative Care - Life Enhancement and Wellness Care

☐ Corrective Care – Removing Cause and Remodeling Soft Tissue

☐ Relief Care – Band- Aid Care Only

☐ Check here if you want the doctor to select the type of care appropriate for your condition

On a Scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: ________________

CANCELLATION POLICY

Time slots are valuable. Therefore we require 12 hours notice of cancellation or your account will be billed ½ of the appointment value.

________ please initial your acknowledgment of this policy

My Extended Benefit Provider is: ____

Please note: We can direct bill many extended insurance plans. Please bring your card to the front desk to see if you qualify.

If you have any questions, please talk to the front desk.

My signature below indicates that I attest that the information indicated here in these forms is correct.

___________________________________	___________________________________	________________________
Signature	**Printed Name**	**Date**

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We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the c circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for chiropractic and other services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send patients informational material and newsletters about our practice and pertinent health issues.
- For the purpose of marketing to external or internal media, I consent to the publication of my name, photograph & any testimonials given either verbal or written.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of chiropractic treatment.

Financial information may be collected and verified in order to make arrangements for the payment of services.

Detailed Patients Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of treatment.
- To other chiropractors and specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other chiropractors and specialists if the patient, with their consent, has been referred by us to the other chiropractor or specialist for treatment.
- To other chiropractors and specialists where those chiropractors have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if we have referred the patient, with their consent, to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our Chiropractic practice, qualified potential purchasers may be granted access as part of the due diligence to process all patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

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Chiropractors are regulated by the Alberta College of Chiropractors who which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

Brost Chiropractic sends out text reminders for every appointment. Our reminders are two way communications enabled.

Cell # ______________________________

☐ **Check here if you do NOT wish to receive text messages.**
You may opt out at anytime. *Standard text message rates may apply. Please check with your carrier*

☐ **YES, please send me email reminders** ______________________________________

☐ Day Before ☐ Morning Of

☐ **YES, please add me to the Birthday List. Email:** _________________________________
*You may opt out at anytime.

☐ **YES, please send me your monthly e-newsletter. Email:** _________________________________
*You may opt out at anytime.

☐ **YES, please me e-receipts. Email:** _________________________________
requested benefit receipts will be printed, as we are unable to email these

☐ **NO - do not send me any correspondence. I have the right to change my mind. At that time I will provide my written approval.**

At any time, you can change your preference, by written correspondence, or the unsubscribe link at the bottom of our emails/texts

I consent to the collection, use and disclosure of my personal information as set out above.

______________________	______________________	______________________
Patient Name	Signature of Patient/Parent/Guardian	Date

____
Print Name of Parent/Guardian