Calgary PRP Clinic
Image-Guided Growth

Clinical Intake Form

Welcome to the Calgary PRP Clinic! We are a private fee-for-service clinic. Please complete the following questionnaire. Your answers will help determine the level of care we are able to provide to you. If we do not believe your condition will respond satisfactorily, we will refer you to the appropriate healthcare provider in a timely manner.

PERSONAL INFORMATION

Date _____

Name: _____ / _____ / _____ _____
Last Name First Name Middle Initial Preferred Name

Birth Date: _____ /_____ /_____ Healthcare #: _____ Province: ❑ AB ❑ Other: _____
YYYY MM DD

Gender: _____ Marital Status: _____ Height: _____ Weight: _____

Current Occupation: _____

Home Address: _____ City: _____ Postal Code: _____

Phone #s: Home _____ Cell _____ Work _____

Do you consent to receiving emails regarding health information, reminders, and important clinic updates?
❑ Yes, I consent to receiving email communication from the clinic.

Email Address: _____

Emergency Contact: _____
Name Relationship Phone Number

Family Doctor (G.P.): _____
Name Location Phone Number

Please be advised that in the interest of inter-professional communication, we will be in touch with your physician regarding the care you receive at our clinic.

Were you referred by your family doctor? ❑ Yes ❑ No

If you were not referred by your doctor, how did you hear about us?
❑ Google ❑ Facebook ❑ GO Adventure Guide ❑ Online News/Newspaper ❑ TV ❑ Radio ❑ Referred by: _____

Is this a workplace injury? ❑ Yes; please be advised that we do not accept WCB cases. ❑ No

Is your injury the result of a motor vehicle accident? ❑ Yes; additional intake forms are required. ❑ No

Our healthcare team meets regularly to discuss interdisciplinary care for the purpose of improved patient care.
Do you consent to details of your case being discussed among our healthcare team? ❑ Yes ❑ No Please initial here: ☐

Our clinic is committed to evidence-based practice and contributing to the scientific research community. All patient information used in research is kept strictly confidential and is used only with permission of the patient.
Do you consent to allow your information to be used in future research? ❑ Yes ❑ No Please initial here: ☐

Re-examinations:
Re-examinations are done at no extra cost in the event of a six-month time lapse between office visits.

Missed Office Visits:
As a courtesy, we ask that our patients give at least 24-hours' notice when cancelling or rescheduling appointments. A Missed Office Visit Fee of $40 may be charged to your account in the event of a missed appointment/late cancellation, with the fee increasing to $85 in the event of 3 separate missed appointments/late cancellations. Please initial here: _____

HEALTH INFORMATION

1. In your own words, please describe your chief complaint and when you first noticed the problem.

_____

_____

2. Is this a new problem, or is it a recurring issue?

   ❑ This is a new problem.

   ❑ This is a recurring issue. How frequently does it occur? _____

3. Have you had any previous treatment for this complaint?

   ❑ Yes. Please list: _____

   ❑ No.

4. What seems to make the problem better? _____

5. What seems to make the problem worse? _____

6. What type of pain is it? (Please check) ❑ Sharp ❑ Stabbing ❑ Achy ❑ Burning ❑ Dull ❑ Other: _____

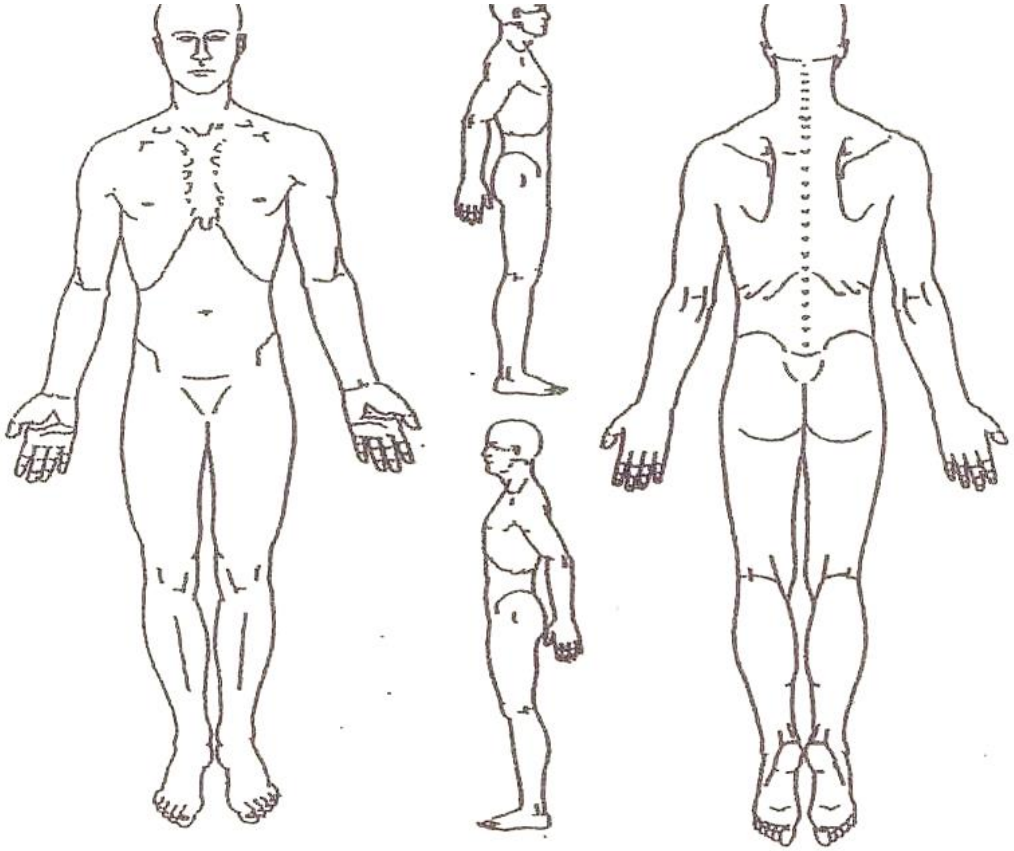
7. At what time of day does your pain seem to be at its worst? _____

8. Using the line scale provided below, please rate the pain you have been experiencing in the last week:

   No Pain 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 Severe Pain

9. Mark the areas on the body drawings below where you feel the following sensations using their corresponding symbols. Include all affected areas.

Sensation: Ache \\\\\ Numbness ++++++ Pins and Needles oooooooo Burning bbbbb Stabbing sssss



HEALTH INFORMATION

1. How would you rate your general health?

Poor 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Excellent

2. Medical conditions and health concerns.
Please list all diagnosed medical conditions (current and past) and any other health concerns.

_____

_____

3. Allergies: (list all known food, drug, and environmental allergies)

_____

_____

4. Medications: (list all prescription & over the counter, as well as dosage)

_____

_____

_____

5. Supplements/Vitamins/Herbals: (list all nutritional and herbal products)

_____

_____

6. Lifestyle

Energy level: Zero 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------- 10 Lots!

Physical activity: ❑ Regular exercise/activity ❑ Some exercise/activity ❑ Sedentary lifestyle ❑ I am immobile

What exercise/activity do you participate in (including times/week, duration and how long you have been doing it)?

_____

_____

Attire/Hygiene

Your first visit to the office includes an initial consultation and an examination for us to best determine how we can help. At the discretion of the doctor, your first visit may not consist of actual treatment.
Some treatments necessitate direct skin contact. Please bring clothing that allows access to the body part to be treated to each appointment, and bathe before attending your appointment.
Please refrain from wearing any cologne, perfumes, or scented lotions while in the clinic.

HEALTH STATUS SURVEY

Present Symptoms: Please check ☑ the box for any **current** symptoms or conditions.
Past Symptoms: Please cross ☒ the box for any **past** symptoms or conditions.

GENERAL SYMPTOMS

- ❑ Headache
- ❑ Concussion
- ❑ Blackouts
- ❑ Loss of consciousness
- ❑ Convulsions
- ❑ Fever
- ❑ Excess sweating
- ❑ Night sweats
- ❑ Night pain
- ❑ Unexplained weight gain/loss
- ❑ Fatigue
- ❑ Poor sleep
- ❑ Generalized pain

MUSCLES AND JOINTS

- ❑ Jaw pain
- ❑ Sore/Stiff neck
- ❑ Low back pain
- ❑ Mid back pain
- ❑ Painful tailbone
- ❑ Shoulder pain
- ❑ Arm/forearm pain
- ❑ Elbow pain
- ❑ Wrist/hand pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Ankle/foot pain
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Loss of strength
- ❑ Muscle twitches

SKIN RELATED

- ❑ Eczema
- ❑ Dermatitis
- ❑ Recent changes in moles
- ❑ Bruise easily
- ❑ Dry skin/hair/nails
- ❑ Oily skin/hair/nails
- ❑ Acne
- ❑ Rashes/itching
- ❑ Boils
- ❑ Hives (allergies)

NEUROLOGIC

- ❑ Dizziness
- ❑ Fainting
- ❑ Numbness or tingling
- ❑ Lack of coordination
- ❑ Problem speaking
- ❑ Problem swallowing
- ❑ Blurred vision
- ❑ Double vision
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression

CARDIOVASCULAR

- ❑ Bleeding disorder
- ❑ High/low blood pressure
- ❑ Chest pain
- ❑ Stroke
- ❑ Hardening of arteries
- ❑ Varicose veins
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Angina
- ❑ Heart disease
- ❑ Blood clots

GASTROINTESTINAL

- ❑ Poor appetite
- ❑ Indigestion
- ❑ Nausea
- ❑ Heartburn
- ❑ Excess hunger/thirst
- ❑ Bloating
- ❑ Vomiting
- ❑ Pain over stomach
- ❑ Pain with bowl movement
- ❑ Constipation
- ❑ Black/bloody stools
- ❑ Hemorrhoids
- ❑ Gall bladder issues
- ❑ Liver issues
- ❑ Ulcer
- ❑ Diarrhea
- ❑ Diabetes

RESPIRATORY

- ❑ Asthma
- ❑ Chronic cough
- ❑ Difficulty breathing
- ❑ Spitting up phlegm/blood
- ❑ Bronchitis
- ❑ Pneumonia

EYES/EARS/NOSE/THROAT

- ❑ Cataracts
- ❑ Eye pain
- ❑ Failing vision
- ❑ Earache/ear discharge
- ❑ Failing hearing
- ❑ Ring/buzz in ears
- ❑ Nose bleeds
- ❑ Frequent colds
- ❑ Sinus infection
- ❑ Thyroid issues
- ❑ Enlarged glands
- ❑ Bleeding gums

GENITOURINARY

- ❑ Trouble urinating
- ❑ Incontinence
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Blood in urine
- ❑ Sores on genitals
- ❑ Prostate trouble
- ❑ Hot flashes
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Irregular/absent cycle
- ❑ Cramping
- ❑ Backache
- ❑ Vaginal discharge
- ❑ Swollen breasts
- ❑ Lump in breasts

Are you currently on birth control?
❑ Yes ❑ No

Are you currently pregnant?
❑ Yes ❑ No

CONSENT TO CHIROPRACTIC TREATMENT

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. CCPA 09.15

● 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.

_____

Name (Please Print)

_____ Date_____ 20____

Signature of patient (or legal guardian)

_____ Date_____ 20____

Signature of Chiropractor