MY INTEGRATED HEALTH CLINIC

CONSULTATION ADMITTANCE FORM

Last Name: ______________________________________ First Name:____ Sex: M / F

Address:____ City________________________ Postal Code:______________

Home Phone:______________ Work Phone:______________ Cell Phone:______________ Cell Phone Provider: ______________

E-mail: ___________________________ Occupation:______________________________ Marital Status:______________________

No. of children:_____________________ Birth date (DD/MM/YYYY):____________________ Alberta Health Care #:_____________

By whom were you referred? _____________________________________

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment? ____

When did your condition begin? ____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI or other tests for this condition? What tests and when? ______________________________

____

Is this condition related to: Work? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Motor vehicle accident? ☐ Yes ☐ No Date of injury: _________________________

Can you perform your daily home activities? ☐ Yes ☐ Yes, only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some ☐ Not at all

Describe your stress level: ☐ None ☐ mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

Is this condition interfering with your: ☐ Work ☐Sleep ☐ Daily Routine ☐ Other_____________________

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):______________________________

____

____

Have you had previous chiropractic care? ☐ Yes ☐ No Doctor: ____________________ Date: ______________________

Family doctor name: ____

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) ______________________________

____

I understand that there is no longer Alberta Health Care coverage for chiropractic care and that I am personally responsible for the entire balance of the Doctor's recognized fee schedule.

Date: __________________________ Patient Signature: ____

MY INTEGRATED HEALTH CLINIC

PERSONAL HEALTH HISTORY

Many health problems are the result of hereditary spinal weakness. This information about your ***immediate family members*** *will give us a better picture of your total health.*

Do you or a family member have a history of the following? If so please circle:

Aids	Alcoholism	Allergies	Arthritis	Asthma
Bed Wetting	Cancer	Cardiovascular Disease	Depression	Diabetes
Epilepsy	Hyperactivity	Learning Disability	Lumbago	Multiple Sclerosis
Schizophrenia	Stomach Ulcers	Venereal Disease	Other ________________________________	

PERSONAL HEALTH HISTORY

Below is a list of conditions which may seem unrelated to your appointment. However, these questions must be answered carefully as these problems can affect you overall diagnosis, treatment plan and possibility of being accepted for care. Circle those which apply.

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection
Diphtheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Lumbago
Rheumatic Fever	Mumps	Influenza	Mental Disorder
Polio	Small Pox	Pleurisy	Eczema

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Difficulty chewing / Clicking jaw

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gas/Bloating after meals
- ☐ Heart burn
- ☐ Black/Bloody stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder trouble
- ☐ Painful/Excessive urination
- ☐ Discoloured urine

C-V-R CODE

- ☐ Chest pain
- ☐ Short breath
- ☐ Blood pressure problems
- ☐ Irregular heart beat
- ☐ Heart problems
- ☐ Lung problems/Congestion
- ☐ Varicose veins
- ☐ Ankle swelling

EENT CODE

- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulties
- ☐ Stuffed nose

MALE/FEMALE CODE

- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain/infection
- ☐ Breast pain/lumps
- ☐ Prostate/Sexual dysfunction
- ☐ Genital herpes

FEMALES ONLY

When was your last period?

____

Are you pregnant?

- ☐ Yes
- ☐ No
- ☐ Maybe

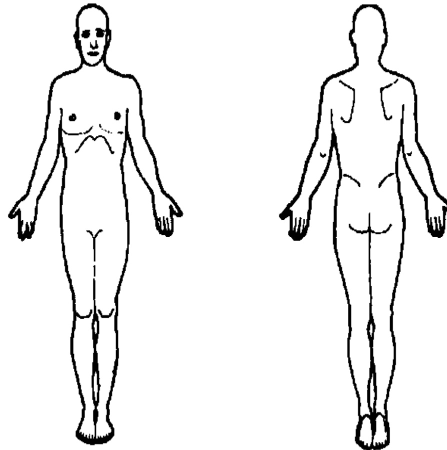
MY INTEGRATED HEALTH CLINIC

HEALTH HISTORY QUESTIONNAIRE

Have you ever been diagnosed or told you have any of the following?
Please circle the correct response.

1.	High blood pressure..	Yes	No
2.	Hardening of the arteries (arteriosclerosis)...	Yes	No
3.	Diabetes..	Yes	No
4.	Tuberculosis..	Yes	No
5.	Cancer, Where?	Yes	No
6.	Heart or blood diseases...	Yes	No
7.	Bone spurs on the neck bones (cervical sprain)....................................	Yes	No
8.	Whiplash injury (flexion-extension injury, cervical sprain)......................	Yes	No
9.	Have you or any of your relatives ever suffered a stroke?	Yes	No
10.	Were you ever a smoker? From___________ To______________	Yes	No
11.	Do you take any medication on a regular basis?....................................	Yes	No
12.	Visual disturbances (blurring, loss, double)	Yes	No
13.	Hearing disturbances (loss, ringing, other noise)....................................	Yes	No
14.	Slurred speech or other speech problems...	Yes	No
15.	Difficulty swallowing..	Yes	No
16.	Dizziness..	Yes	No
17.	Loss of consciousness, even momentary blackouts...............................	Yes	No
18.	Numbness, loss of sensation, strength or weakness in the face, fingers hands, arms, legs or any other parts of the body…..	Yes	No
19.	Sudden collapse without loss of consciousness....................................	Yes	No

Indicate the location of your pain by shading in the appropriate area



Indicate the severity of the pain by circling a number.

No Pain **| 0 1 2 3 4 5 6 7 8 9 10 |** Extreme Pain

MY INTEGRATED HEALTH CLINIC

FEE SCHEDULE

Service:	Adult	Student/Senior
30 Minute Massage	$65.00	$55.00
45 Minute Massage	$75.00	$65.00
60 Minute Massage	$90.00	$75.00
90 Minute Massage	$120.00	$100.00

1. Payment in **CASH** or **CHEQUE** is required at the time service is rendered. If you have any questions or concerns about this pricing please ask your therapist.

2. Most private Insurance Companies such as Alberta Blue Cross, provide full or partial coverage of massage therapy claims. These policies are between you and your company. We do not direct bill any third party Insurance company (unless it is a Motor Vehicle Accident claim). We can provide you with receipts of your visits, providing your account has been kept up to date. Interest will be charged on all overdue accounts at 4% per month (minimum $1.00). Overdue accounts where patients have not provided payment options and have been overdue for more than 3 months will be sent to a Collections Agency.

3. In the case of third party intervention in your massage therapy care (such as a Motor Vehicle Accident) you are authorizing the office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of a claim. If you have any questions or concerns about the release of said information, do not hesitate to mention this to front desk staff.

SIGNATURE: ____

(signature of person financially responsible if patient is under age of 18)

MY INTEGRATED HEALTH CLINIC

MASSAGE THERAPIST WAIVER & INFORMED CONSENT

I,__________________________ hereby fully understand that the practice of Massage Therapy provided by any and all massage therapists is separate and distinct from the practice of Chiropractic provided by Dr. G Menzies PC of My Integrated Health Clinic.

I hereby waive all liability towards Dr. G Menzies PC should any injury or malpractice occur from the practice of Massage Therapy on the premises of the My Integrated Health Clinic.

I further acknowledge that manual therapy techniques do have or may have associated risks. In particular you should note:

a) While rare, some patients may experience short term muscular soreness or aggravation of symptoms.
b) Even more rare (but not limited to) are muscular or ligament strain, bruising, or rib fracture.

I acknowledge that I have discussed or have had the opportunity to discuss with my therapist, the nature and purpose of treatment in general and my treatment in particular as well as the contents of this consent.

I realize that 24 hour notice is required for cancellations otherwise I will be billed for the full amount of my massage. If am late for my appointment time, the massage time will reflect this difference; however the full amount for the original appointment will be billed. We will endeavor to give a reminder (call/e-mail/ text) if requested; but responsibility for missed appointments belong to the client and will be charged.

I consent to the massage therapy treatments offered or recommended to me by my therapist. I intend this consent to apply to all my present and future massage treatments.

Dated this ___________ day of ____________________, 20___.

Signature (to be signed by parent if patient is under the age of 18): ____

Witness Name: ____________________________ Witness Signature: ______________________________