Linden Chiropractic

#102B Central Ave. E Linden, Alberta

Email: reception@lindenchiro.ca

Phone: 403-546-2627

Consultation Admittance Form

Last Name:_____ First Name: _____ Gender: M / F

Date of Birth: (YYYY-MM-DD) _____ Age: _____ Height: _____ Weight:_____

Alberta Health Care #_____ Occupation: _____

Address: _____ City, Province: _____ Postal Code: _____

Phone: (Home) _____ (Cell) _____ Emergency Name and Contact Phone: _____

Email: *(for invoices, correspondence, and updates)*: _____

Family Doctor: Dr._____

I give consent for my clinical information to be communicated to my family doctor or specialist listed (Yes / No)

How did you find out about Linden Chiro? _____Whom may we thank for your referral? _____

Please fill in the blanks to the best of your ability

Reason(s) for appointment: _____

When did this begin? _____

Has it been improving or worsening since it began? _____

What makes it feel better? _____

What makes it feel worse? _____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had any Diagnostic Imaging or tests for this condition? ☐ Yes ☐ No

If yes, what type of Imaging or test and when?_____

Is this a work-related injury? ☐ Yes ☐ No

Has your employer been notified? ☐ Yes ☐ No ☐ Not Applicable

Is this a Motor Vehicle Accident (MVA)? ☐ Yes. ☐ No When did the accident occur? _____

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

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

List any severe illnesses, major hospitalizations, traumas and/or surgeries (including MVA), allergies: _____

_____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. _____ Date of last visit: _____

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: _____

_____

Date: _____ **Patient signature**: _____

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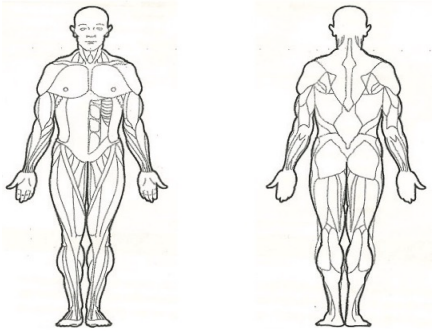
Health History Questionnaire

Patient name _____ **Date**_____

Have you ever been diagnosed or told you have any of the following? 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---------- Yes No
   Where? _____
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? ---------- Yes No
    From_____to_____
11. Do you take medication on a regular basis? ---------- Yes No
12. Visual disturbances (blurring, loss, double vision) ---------- 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, loss of 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(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No Pain Extreme Pain

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Systems Review

Patient name _____ **Date**_____

Circle any conditions that are **presently** causing you a problem.
Underline those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney
Nervousness	Difficulty breathing	infection
Weight loss	Asthma	Prostate trouble
Weight gain		Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen	Birth control pills
Enlarged glands	joints	Miscarriages
	Spinal curvature	Complications with pregnancy
	Arthritis	Pregnant? Y / N Week?
	Fractures	Other:

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CANCELLATION, PAYMENT AND PERSONAL INFORMATION AGREEMENT

PAYMENT INFORMATION **Initial: _____**

Payment is expected when services are rendered.

CANCELLATION POLICY AND MISSED VISIT AGREEMENT **Initial: _____**

If you cannot attend your appointment, please let us know **the day before**. If less than 24 hours' notice, we reserve the right to charge for the time you reserved.

THIRD PARTY AND INSURANCE - USE OF PERSONAL INFORMATION **Initial: _____**

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, may be used by the insurer and/or plan administrator and their service provider(s) for the purpose of assessing your claims, underwriting, investigating, auditing, administering the group benefits plan, and for the investigation of fraud and/or plan abuse.

I authorize the insurer and/or plan administrator, and their service provider(s) to:

- use my personal information for the above purposes;
- exchange personal information with any individual or organization, including:
  - healthcare professionals, investigative agencies, insurers, reinsurers, administrators of government benefits, and other benefits programs;
- exchange personal information related to any claims submitted with the plan member or a person acting on behalf of the plan member; and,
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law. I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

I authorize my healthcare provider to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT **Initial**: _____

Additional Consent Applicable to Insurance Plan Member(s) Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s), for the purposes described above. I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree, that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my plan sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my plan sponsor, for that purpose.

I authorize Linden Chiro to submit claims electronically to the group benefits plan. I also agree and authorize the insurer/plan administrator to issue payment to Linden Chiro directly.

PROVIDER INFORMATION

Linden Chiropractic
102B Central Ave E
Linden, Alberta T0M-1J0
Phone: (403) 546-2627

Patient Name: _____

Date of Birth YYYY/MM/DD: _____

Insurance Company: _____

Plan Number: _____

Member Number: _____

Plan Holder Name: _____

BY SIGNING BELOW, I ACKNOWLEDGE HAVING READ THIS FORM IN ITS ENTIRETY AND AGREE TO ALL TERMS CONTAINED IN THIS AGREEMENT.

Patient Name: _____ **Photo ID provided:** YES / NO

Patient Signature: _____ **Date:** _____

Witness Name and Signature: _____ **Date:** _____