P:403.278.1405
F:403.278.1475
#220 9950 Macleod Trail SE
Calgary AB T2J 3K9
mail@activesportstherapy.ca

Name _____Date _____ Alberta Health Care #_____

Date of Birth _____ Age_____ Gender □ M □ F Marital Status_____ # of Children_____

Address_____ City_____ Province_____ Postal Code_____

Home Phone#_____ Cell Phone #_____ Email_____

Please (*) best number to call you at during daytime hours (8:30am-6:00pm)

Reminders: □ Email □Text Message; Cell Phone Provider: _____ □ Phone Call

Your Occupation_____ Company_____ City_____ Work #_____

Emergency Contact/ Guardian's Name: _____ Phone_____

How did you hear about us? □ Google □Yellow Pages □Sign □Website □Friend_____ □Other_____

Do you have extended health benefits? □Yes □No Company_____

Do you currently wear orthotics? □ Yes □ No Are you interested in gait analysis to see if orthotics will benefit you? □ Yes □ No

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GOALS FOR CARE: Check all that apply

□RELIEF I want to feel better for the least amount of my time and money.

□CORRECTION I want to correct the problem so it doesn't come back.

□MAINTENANCE I want to preserve the progress I've made.

□PREVENTION I want to avoid losing my health.

□PERFORMANCE I want my body in peak condition for my sport or activity.

Are you interested in any of our other services?

□ Massage Therapy □ Integrated Medicine

□ Physiotherapy □ Holistic Nutritional Counselling

□ Chiropractic

□ Naturopathic Medicine

□ Muscle Activation Technique

MAIN ISSUE/CONCERN_____

When did it **start**? _____ What do you think caused it? _____

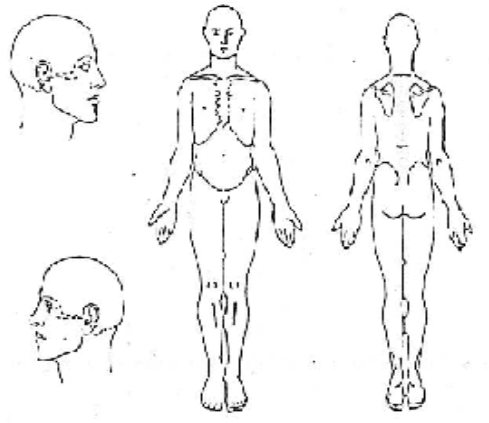
What would you like to do but can't because of this problem? _____

Other professionals seen for this _____ How many treatments? _____ When? _____

_____ How many treatments? _____ When? _____

Is this **work related**? □Yes □ No If yes, have you reported to your employer? □Yes □No

Related to **automobile accident**? □ Yes □ No **WCB claim #**_____



What makes it **better** (positions/activities/movements)?_____

What makes it **worse** (positions/activities/movements)?_____

What % of each day does it **bother you**? (Circle one)

0% 25%(intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Does it **affect you** at:

Work Play/Activities/Exercise Sleep Romance/Love life

Have you had this condition **before**? □Yes □No **When**?_____

Is your condition getting **better**? getting **worse**? staying the s**ame**?

0 1 2 3 4 5 6 7 8 9 10

Average Pain No Pain |------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Unbearable

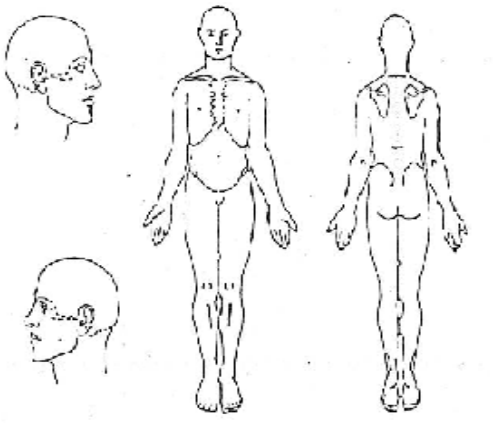
2ND ISSUE/CONCERN _____

When did it **start**? _____ What do you think caused it? _____

What would you like to do but can't because of this problem? _____
List other professionals seen for this _____
_____ How many treatments? _____ When ?_____

Is this **work related**? □Yes □ No If yes, have you reported to your employer? □Yes □No

Related to **automobile accident**? □ Yes □ No **WCB claim #**_____



What makes it **better** (positions/activities/movements)?_____

What makes it **worse** (positions/activities/movements)?_____

What % of each day does it **bother you**? (Circle one)

0% 25%(intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Doest it **affect you** at:

Work Play/Activities/Exercise Sleep Romance/Love life

Have you had this condition **before**? □Yes □No **When**?_____

Is your condition getting **better**? getting **worse**? staying the s**ame**?

0 1 2 3 4 5 6 7 8 9 10

Average Pain No Pain |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Unbearable

---

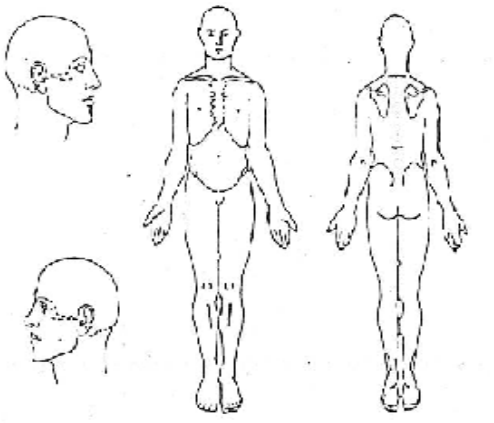
3RD ISSUE/CONCERN _____

When did it **start**? _____ What do you think caused it? _____

What would you like to do but can't because of this problem? _____
List other professionals seen for this _____
_____ How many treatments? _____ When ?_____

Is this **work related**? □Yes □ No If yes, have you reported to your employer? □Yes □No

Related to **automobile accident**? □ Yes □ No **WCB claim #**_____



What makes it **better** (positions/activities/movements)?_____

What makes it **worse** (positions/activities/movements)?_____

What % of each day does it **bother you**? (Circle one)

0% 25%(intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Doest it **affect you** at:

Work Play/Activities/Exercise Sleep Romance/Love life

Have you had this condition **before**? □Yes □No **When**?_____

Is your condition getting **better**? getting **worse**? staying the s**ame**?

0 1 2 3 4 5 6 7 8 9 10

Average Pain No Pain |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Unbearable

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PERSONAL HEALTH HISTORY – The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- □ **Recent accident** such as a fall, whiplash, or blow to the head
- □ Spinal/back/neck problem
- □ Muscle spasms
- □ Restricted movement
- □ Numbing or tingling of hands or feet or radiating pain
- □ Headaches or Migraines
- □ Sinus problems
- □ Nausea
- □ Depression
- □ Anxiety or difficulty with stress
- □ Dizziness or vertigo
- □ Vision problems
- □ Hearing problems
- □ Sleep troubles
- □ Asthma or breathing problems
- □ Digestive problems
- □ Heartburn/ Acid Reflux
- □ Menstrual problems
- □ Jaw or mouth problems
- □ Arm, shoulder, elbow or hand problems
- □ Leg, hip, knee or foot problems

DIAGNOSED CONDITIONS

- □ Born with bone or joint disorder
- □ Degenerative arthritis
- □ Rheumatoid arthritis
- □ Compression fracture
- □ Heart attack or heart disorders
- □ History of stroke or aneurysm
- □ Cancer
- □ Diabetes
- □ Gout
- □ Lupus
- □ Ankylosing spondylosis
- □ Immune suppression treatment or disorder from chemotherapy, organ transplant, drugs, etc.
- □ 3 or more months of steroid medication or Intravenous drugs (past or present)
- □ Tuberculosis
- □ Hepatitis B or HIV infection
- □ Thyroid or hormone disorder
- □ High blood pressure
- □ Convulsions/epilepsy
- □ Other:

SPECIFIC PAIN IN THE BODY

- □ Difficulty swallowing because of neck pain
- □ Pain or electric shock in arms or legs when moving neck
- □ Leg pain worse with exercise
- □ Numbness of inner thighs
- □ Back pain with urinary problems
- □ Severe pain that interrupts sleep
- □ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- □ Poor balance
- □ Loss of bowel or bladder control
- □ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- □ Memory loss after injury
- □ Recent, unexplained weight loss
- □ Recent progressive muscle weakness or shaking
- □ Recent or current fever over 102°C

Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal or work accidents / fractures / dislocations / & / or illnesses you've had and the **dates**:

_____
_____
_____

Current Medications & Drugs: Please circle the ones that apply

Pain Relievers	Appetite Suppressant	Thyroid	Birth Control	Blood Pressure
Laxatives	Cortisone	Sleeping Pills	Antibiotics	Tranquilizers
Antacid	Cholesterol	Anti Inflammatory	Muscle Relaxants	Anti-anxiety

Recreational: _____

Rx: _____ Dosage: _____ Diagnosis: _____
Rx: _____ Dosage: _____ Diagnosis: _____
Rx: _____ Dosage: _____ Diagnosis: _____

List Current Supplements: _____
Why are you taking them: _____
Over the Counter _____

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YOUR LIFESTYLE

Height: _____ Weight: _____ Has your **weight** changed recently? Gained: _____lbs. Lost: _____lbs. OR No change.
How many hours of sleep: _____ Drink **coffee/tea/energy** drink? _____ cups/day
Sleep position: Side Front Back Do you **Smoke**? No Yes _____cigs/day
Quality of sleep: Poor Moderate Excellent **Exercise**: No Yes, _____/ week
Grind your teeth/clench? No Yes Cardio Weights Core Yoga Pilate
How many **hours do you sit**? _____/day
For Women: Are you pregnant? □Yes □ No Date of last Period _____
Have you ever had an epidural? □Yes □ No
Stress level at home and at work. Mild Moderate Severe Extreme

FAMILY HISTORY Circle - Please state **who** has/had condition(eg. maternal grandma), **how old** they were when **diagnosed, & what type** (eg. Lung CA)

Spine problems / Autoimmune disorders / Arthritis / Cancer (Type: _____) Diabetes / Heart disease / Stroke / Kidney disease

Mental illness / Seizures

Other: _____ Please state who has/had the condition: _____

Your **Medical Practitioner's** Name: _____ Phone: _____

Date last seen: _____ Reason for visit: _____ Recent medical testing (circle): X-rays Blood test

Other: _____

Permission to contact your medical doctor (Signature) _____

Have you been under Chiropractic care before (Circle)? Yes No Result: Excellent Good Fair Poor

Chiropractor: _____ Years of care: _____ Last date seen: _____ Conditions: _____

I, _____ understand Active Sports Therapy *will not* disclose any of my personal medical information without my signed consent.

I understand that all services are to be paid in full at the time of service, unless other arrangements have made and agreed upon in writing. Please note that we require a minimum of 24 hours notice for any cancellations or changes. ***Massage and MAT appointments will be charged in full if missed***.

_____ _____ _____
Signature Date Guardian Signature (if applicable)

_____
Witness

Office Fees

We accept Cash, Debit & Credit Card
We can direct bill to insurance companies.

CHIROPRACTIC
First Visit……$120.00
(*Assessment and Treatment*)

Regular Visit……..$79.00
(*Active Release Therapy and an Adjustment*)

Regular Visit & Laser……..…$100.00
Extended Visit……$100.00
(2 or more body parts or extended time needed for difficult cases)
Adjustment Only……$50.00

ORTHOTICS
Custom Orthotics with assessment…….. $450.00
2 Pairs…….…. $700.00

PHYSIOTHERAPY
New Assessment…… $120.00
Regular Visit…….. $79.00
IMS…… $79.00

MASSAGE
15Minutes…….. $45.00 +gst
30Minutes…….. $65.00 +gst
45Minutes…….. $80.00 +gst
60Minutes…….. $95.00 +gst
90Minutes…….. $145.00 +gst
(Includes GST)

MAT
Muscle Activation Technique…… $99.75
(Includes GST)

NUTRITIONAL COUNSELOR
Initial Visit + 2 Follow-up……$200.00
Follow-up …….....$60.00

NATUROPATHIC
New Patient …….....$180.00
Follow-up/Acupuncture …….$85.00

Prices are subject to change

_____ _____
Signature Date