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 a gait analysis to see if they are required? Yes No

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GOALS FOR CARE: Check all that apply **Are you interested in any of our other services?**

RELIEF: I want to feel better for the least amount of my time and money.	Massage Therapy	Integrated Medicine
CORRECTION: I want to correct the problem so it doesn't come back.	Physiotherapy	Holistic Nutritional Counselling
MAINTENANCE: I want to preserve the progress I've made.	Chiropractic	
PREVENTION: I want to avoid losing my health.	Naturopathic Medicine	
PERFORMANCE: I want my body in peak condition for my sport or activity.	Muscle Activation Technique	

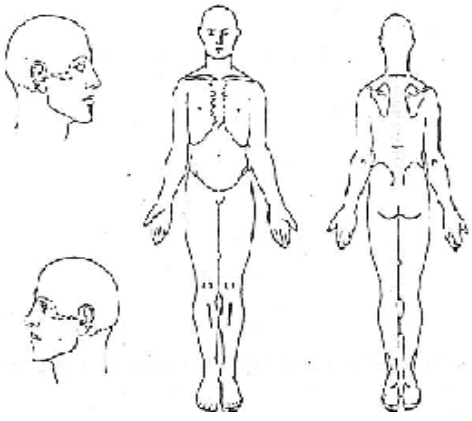
MAIN ISSUE/CONCERN_____

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? _____



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

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

What % of each day does it **bother you**?

Does it **affect you** at (check all that apply):

Work Play/Exercise Sleep Romance/Love Life N/A

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

Is your condition getting: **better**? **worse**? **same**?

Average Pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

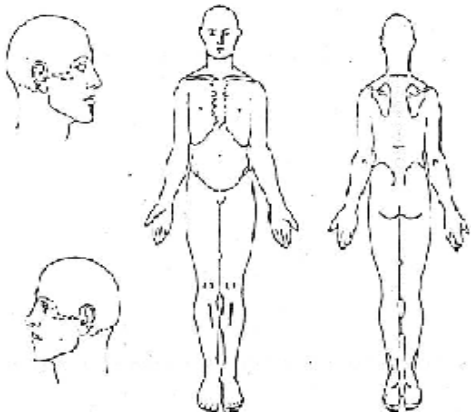
Is this **work related**? Yes No If yes, have you reported to your employer? Yes No

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

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



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

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

What % of each day does it **bother you**?

Doest it **affect you** at (check all that apply):

Work Play/Exercise Sleep Romance/Love Life N/A

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

Is your condition getting: **better**? **worse**? s**ame**?

Average Pain:

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

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

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

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**:

List Current Medications and Drugs:

List Current Supplements:

Your Lifestyle:

Height: _____ Weight: _____

How many hours of sleep/night? _____

Sleep Position:

Quality of Sleep:

Do you grind/clench your teeth? Yes No

How many hours do you sit? _____/day

For Women**:** Are you **pregnant**? Yes No

Date of your **last period**? _____

Have you had an **epidural**? Yes No

Has your **weight** changed recently?
Gained: _____lbs. / Lost: _____lbs. / No Change

Do you drink **coffee/tea/energy drinks**? Yes _____/day No

Do you **smoke?** Yes _____/day No

Do you **exercise?** Yes _____/week No

Type of Exercise:

Stress level at **home**:

Stress level at **work**:

Family History:

Spine problems	Autoimmune Disorders	Arthritis	Cancer	Diabetes
Heart disease	Stroke	Kidney disease	Mental Illness	Seizures

Other: _____ Which family member (incl. age of diagnosis)? _____

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

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

Other

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 some major 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

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