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

Thank you for filling out our health questionnaire package. The more we know, the better we can help!

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 (9:00am-7:00pm)

Reminders: □ Email □Text Message; circle: Telus, Rogers, Bell, Freedom, Koodo, Virgin, Fido, Other: _____ □ 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 (insurance)? □No □Yes; Company_____

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

---

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 □ Traditional Chinese Medicine

□ Naturopathic Medicine

□ Muscle Activation Technique

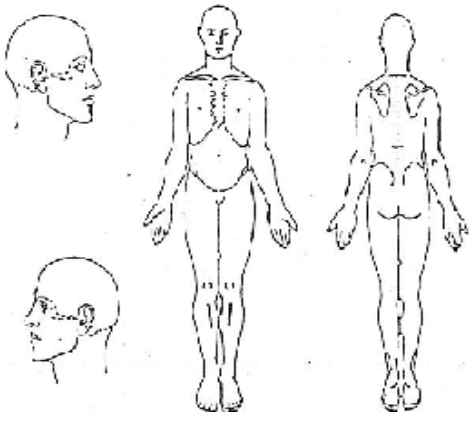
MAIN ISSUE/CONCERN (additional space on next pg)_____

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**?

□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**? □No □Yes;**When**?_____

Is your condition: □getting **better**? □getting **worse**? □staying the 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 the injury to your employer? □Yes □ No

WCB claim #_____

Is this related to **automobile accident**? □ Yes □ No

If yes, please speak to our front staff about MVA billing.

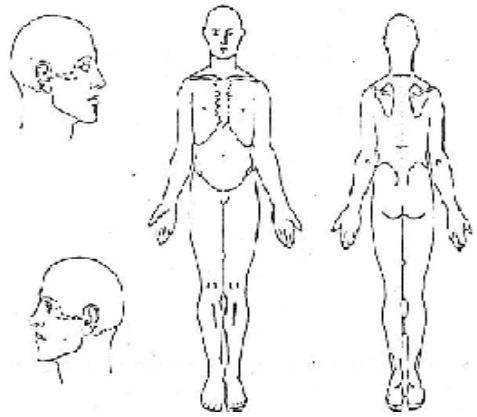
2ND ISSUE/CONCERN _____

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**?

□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**? □No □Yes; **When**?___ _____

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

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 the injury to your employer? □Yes □ No

WCB claim #_____

Is this related to **automobile accident**? □ Yes □ No

If yes, please speak to our front staff about MVA billing.

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. Again, the more we know, the more we can help! ☺

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 / and/or illnesses you've had and their **dates**:

_____

_____

_____

_____

_____

List Current **Medications and Drugs:**

_____

_____

List Current **Supplements:**

_____

_____

Your Lifestyle:

Height: _____ Weight: _____

How many hours of **sleep**/night? _____

Sleep Position: Side Front Back

Quality of Sleep: Poor Moderate Excellent

Do you grind/clench your teeth? □Yes □No

How many hours do you **sit** per 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**? □No □Yes; _____/day

Do you **smoke?** □No □Yes; _____cigarettes per day

Do you **exercise?** □No □Yes; _____ times per week

□Cardio □Weights □Core □Yoga □Other: _____

Stress level at **home**: □Mild □Moderate □Severe □Extreme

Stress level at **work**: □Mild □Moderate □Severe □Extreme

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-Ray/Ultrasound □Blood test

Other: _____

I, _____(print name) 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

Active Sports Therapy Office Fees

CHIROPRACTIC

Initial Visit (Assessment and treatment)	$125
Regular Visit (ART with/without an Adjustment – includes IFC, US, and Game Ready)	$85
Extended Visit (Extended time needed for 2+ body parts or difficult cases)	$120
Adjustment Only	$60
New Assessment	$100

PHYSIOTHERAPY

Initial Visit	$125
Regular Visit (Includes IMS, IFC, US, and Game Ready)	$85
New Assessment	$100

LASER

Regular Visit + Laser	$100
Regular Visit + Laser (Multiple Body Parts)	$120
Laser Only (One Body Part)	$60
Laser Only (Multiple Body Parts)	$100

SHOCKWAVE

Regular Visit + Shockwave	$120
Shockwave Only	$100

MASSAGE THERAPY

90 Minutes	$145 + gst
60 Minutes	$95 + gst
45 Minutes	$80 + gst
30 Minutes	$65 + gst
15 Minutes	$45 + gst

MUSCLE ACTIVATION TECHNIQUE (MAT)

Muscle Activation Technique Treatment	$95 + gst

NUTRITIONAL COUNSELLOR

Initial Visit + 2 Follow Up Appointments	$200
Follow Up Appointment	$60

NATUROPATHIC DOCTOR

Initial Visit	$180
Follow Up or Acupuncture	$85

TRADITIONAL CHINESE MEDICINE

Initial Visit	$125
Initial Herbal or Nutritional Visit	$75
Acupuncture and/or Cupping	$65
Follow Up (60 minutes)	$90
Follow Up (30 Minutes)	$55

ORTHOTICS

Custom Footmaxx Orthotics + Assessment (1 Pair)	$525
Custom Footmaxx Orthotics + Assessment (2 Pairs)	$800

Prices subject to change.