

# Active Sports Therapy

WILLOW PARK WESTMAN VILLAGE

AST Willow Park  
Ph: 403-278-1405  
#220 9950 Macleod Trail SE  
Calgary AB T2J 3K9  
mail@activesportstherapy.ca

AST Westman Village  
Ph: 825-509-4780  
148 Mahogany Centre SE  
Calgary AB T3M 2V6  
WVmail@activesportstherapy.ca

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

Prefix:  Dr.  Mr.  Mrs.  Ms.  Miss  Mx.  Other: \_\_\_\_\_ Preferred pronouns:  He/Him  She/Her  They/Them

Name \_\_\_\_\_ Date \_\_\_\_\_ Alberta Health Care # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_ # of Children \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Email \_\_\_\_\_

Please (\*) best number to reach you during daytime hours (8:00am-8:00pm)

(Email is used for appointment reminders, correspondence, and clinic updates).

Reminders:  Email  Text Message  Phone Call  No Reminders

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  Traditional Chinese Medicine
- Chiropractic  EmSculpt Neo®
- Naturopathic Medicine  Emsella®
- Acupuncture

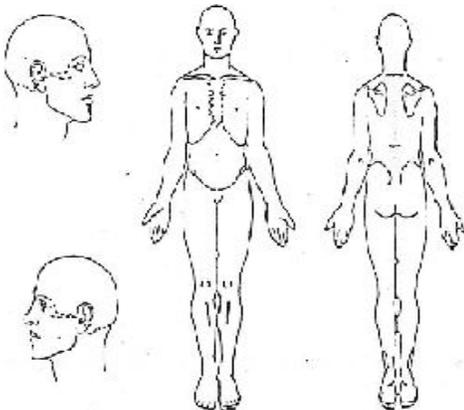
**MAIN ISSUE/CONCERN** (room for more on next pg) \_\_\_\_\_

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 **same**?

## 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?

No  Yes; WCB claim # \_\_\_\_\_

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

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

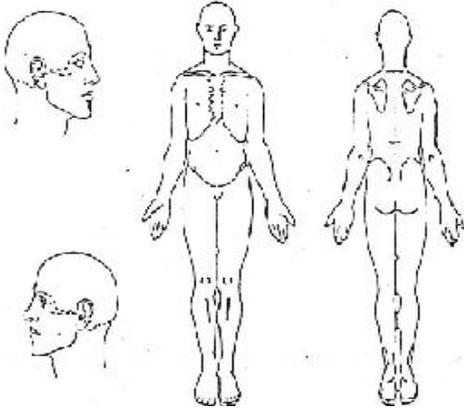
## 2<sup>ND</sup> ISSUE/CONCERN

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 **same**?

**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?*

No  Yes; WCB claim # \_\_\_\_\_

Is this related to an 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
- Urinary leakage
- Urinary urgency
- 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°F

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

---

---

---

List Current **Medications and Drugs**:

---

---

List Current **Supplements**:

---

---

**Your Lifestyle:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Has your **weight** changed recently? Gained: \_\_\_\_\_lbs. / Lost: \_\_\_\_\_lbs. / No Change

How many hours of **sleep**/night? \_\_\_\_\_ Do you drink **coffee/tea/energy drinks**? No Yes; \_\_\_\_\_per day

**Sleep Position:** Side Front Back Do you drink **alcohol**? No Yes; \_\_\_\_\_drinks per week

**Quality of Sleep:** Poor Moderate Excellent Do you **smoke cigarettes**? No Yes; \_\_\_\_\_cigarettes per day

**Do you grind/clench your teeth?** Yes No Do you use **cannabis**? No Yes; \_\_\_\_\_times per week

How many hours do you **sit** per day? \_\_\_\_\_ Do you **exercise**? No Yes; \_\_\_\_\_times per week

For those with a uterus: Are you **pregnant**? Yes No Cardio Weights Core Yoga Other: \_\_\_\_\_

Date of your **last period**? \_\_\_\_\_ Stress level at **home**: Mild Moderate Severe Extreme

Have you had an **epidural**? Yes No Stress level at **work**: Mild Moderate Severe Extreme

**Family History:** (please circle those which apply)

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 been made and agreed upon in writing. Please note that we require a minimum of 24 hours notice for any cancellations or changes to avoid an associated fee. Massage Therapy and Dr. Lovely appointments will be charged in full if missed or cancelled within 24 hours of the appointment time.

\_\_\_\_\_  
Signature Date Guardian Signature (if applicable)

\_\_\_\_\_  
Witness

# Active Sports Therapy Office Fees

## CHIROPRACTIC

Initial Visit (Assessment and treatment)	\$150
Regular Visit (ART with/without an Adjustment – includes dry needling, IFC, US, and Game Ready if applicable)	\$100
Extended Visit (Extended time needed for 2+ body parts or difficult cases)	\$125
Adjustment Only	\$80
New Assessment	\$125

## DR. FIONA LOVELY CHIROPRACTIC

(please inquire for functional hormone or functional neurology)

Initial Visit (Assessment only)	\$150
Adjustment	\$75
K-Laser Treatment	\$90
K-Laser Package of 3	\$240
K-Laser Package of 6	\$480
No-Show or <24h Cancellation	Full Charge of Booked Appointment

## PHYSIOTHERAPY

Initial Visit	\$150
Regular Visit or Dry Needling (Includes IFC, US, and Game Ready if applicable)	\$100
Regular Visit + Dry Needling	\$110
New Assessment	\$125
No-Show or <24h Cancellation	\$25

### PELVIC FLOOR PHYSIOTHERAPY

Initial Visit	\$180
Follow Up Appointment	\$132
No-Show or <24h Cancellation	\$25

### VESTIBULAR PHYSIOTHERAPY

Initial Visit	\$180
Follow Up Appointment	\$132
No-Show or <24h Cancellation	\$25

## LASER THERAPY

[Any Visit Type] + Laser	+ \$25
Laser Only	\$75

## SHOCKWAVE THERAPY

(Willow Park location only)

[Any Visit Type] + Shockwave	+ \$25
Shockwave Only	\$75

## MASSAGE THERAPY

90 Minutes	\$185 + gst
60 Minutes	\$125 + gst
45 Minutes	\$100 + gst
30 Minutes	\$80 + gst
No-Show or <24h Cancellation	Full Charge of Booked Appointment

## NATUROPATHIC DOCTOR

(please inquire for acupuncture and prolotherapy)

Initial Visit	\$198
Follow Up Appointment	\$95
No-Show or <24h Cancellation	Full Charge of Booked Appointment

## TRADITIONAL CHINESE MEDICINE AND ACUPUNCTURE

(please inquire for facial and auricular appointments)

Initial Visit	\$150
Follow Up (60 minutes)	\$125
No-Show or <24h Cancellation	Full Charge of Booked Appointment

## ORTHOTICS

(Willow Park location only)

Custom Footmaxx Orthotics (1 Pair) + Dynamic Gait and Pressure Analysis Report	\$550+gst
Custom Footmaxx Orthotics (2 Pairs) + Dynamic Gait and Pressure Analysis Report	\$900+gst
Add Premium Covering (per Pair)	+ \$10+gst

Prices subject to change.