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. The more we know, the better we can help!

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 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 ☐ Other _____ ☐ Friend

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 ☐

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/activity.

Are you interested in any of our other services?

Massage Therapy ☐ Integrated Medicine

Physiotherapy ☐ Holistic Nutritional Counselling

Chiropractic

Naturopathic Medicine

Muscle Activation Technique

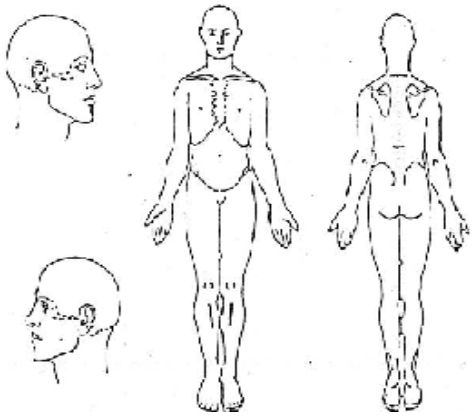
MAIN ISSUE/CONCERN _____

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? _____



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

Related to **automobile accident**? ☐ Yes ☐ No

If yes, have you reported to your employer? ☐ Yes ☐ No

WCB claim #_____

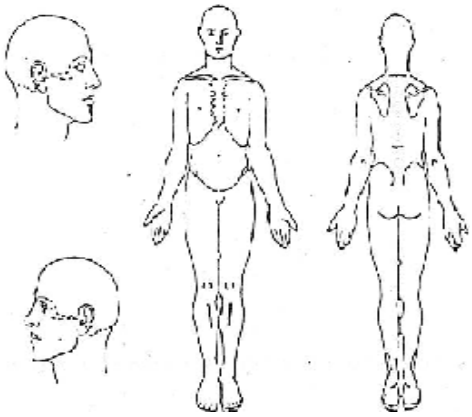
2nd ISSUE/CONCERN _____

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**? ☐ **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 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. 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°F

Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal or work accidents / fractures / dislocations / and/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 drink **alcohol?**	☐ Yes	_____ /week	☐ No
Do you **smoke cigarettes?**	☐ Yes	_____ /day	☐ No
Do you use **cannabis?**	☐ Yes	_____ /week	☐ 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

Active Sports Therapy Office Fees

CHIROPRACTIC

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

PHYSIOTHERAPY

New Assessment	$125
Regular Visit	$85
IMS	$85

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

MUSLE ACTIVATION THERAPY (MAT)

Muscle Activation Technique	$95 + gst

NUTRITIONAL COUNSELLLOR

Initial Visit + 2 Follow-up	$200
Follow-up	$60

NATUROPATHIC

New Patient	$180
Follow-up/Acupuncture	$85

TRADITIONAL CHINESE MEDICINE

Initial Visit	$120
Initial Herbal or Nutritionist Visit	$75
Acupuncture and/or Cupping	$65
Follow Up (60 minutes)	$90
Follow Up (30 minutes)	$55

ORTHOTICS

Custom Footmaxx Orthotics with assessment (1 Pair)	$525
Custom Footmaxx Orthotics with assessment (2 Pair)	$800

Prices are subject to change.