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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 _____ 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)

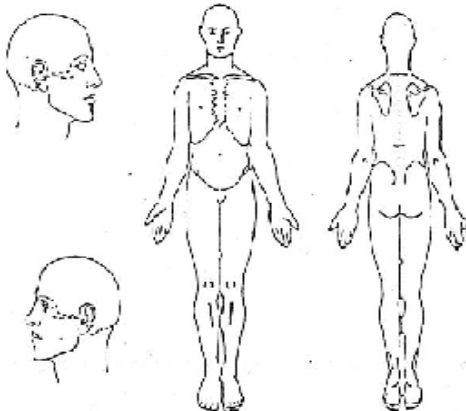
- RELIEF: I want to feel better for the least amount of my time and money.
- CORRECTION: I want to correct the problem so it doesn't come back.
- MAINTENANCE: I want to preserve the progress I've made.
- PREVENTION: I want to avoid losing my health.
- PERFORMANCE: I want my body in peak condition for my sport or activity.

Are you interested in any of our other services?

- Massage Therapy Integrated Medicine
- Physiotherapy Holistic Nutritional Consulting
- Chiropractic Traditional Chinese Medicine
- Naturopathic Medicine
- Muscle Activation Technique

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?

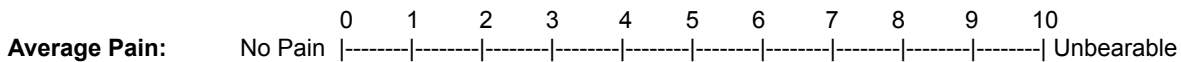
- 0% 25%(intermittent) 50% (Occasional) 75%(Frequent) 100%(Constant)

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**?



Is this **work related**? Yes No

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

WCB claim # _____

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

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

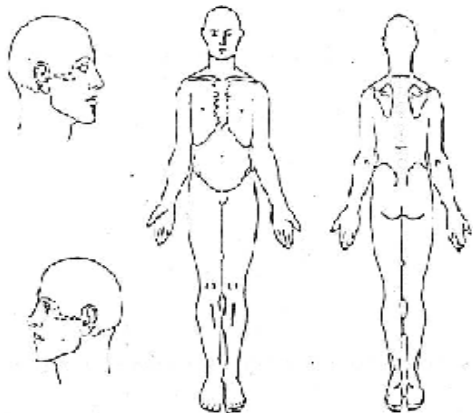
2ND ISSUE/CONCERN _____

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**?

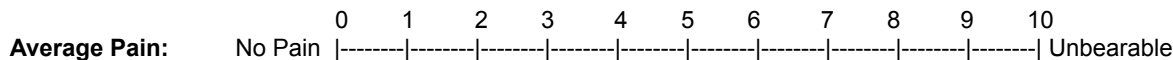
- 0% 25%(intermittent) 50% (Occasional) 75%(Frequent) 100%(Constant)

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 **same**?



Is this **work related**? Yes No

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

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

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

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 / & 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 Women: 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.

Massage, MAT, or 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)	\$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)	\$100
Adjustment Only	\$60
New Assessment	\$100

DR. FIONA LOVELY CHIROPRACTIC

(please inquire for functional hormone or functional neurology)

Initial Visit (Assessment only)	\$125
Adjustment	\$60
Laser Treatment	\$80
Laser Package of 3	\$216
Laser Package of 6	\$432

PHYSIOTHERAPY

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

PELVIC FLOOR PHYSIOTHERAPY

Initial Visit	\$170
Follow Up Appointment	\$120

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	\$160 + gst
60 Minutes	\$105 + gst
45 Minutes	\$90 + gst
30 Minutes	\$70 + gst
15 Minutes	\$50 + gst

MUSCLE ACTIVATION TECHNIQUE (MAT)

MAT Initial 2 Sessions (50 Minutes Each)	\$180 + gst
MAT Full Session (50 Minutes)	\$105 + gst
MAT Half Session (25 Minutes)	\$65 + gst
MAT Package of 10 (50 Minutes Each)	\$850+gst
MAT Package of 10 (25 Minutes Each)	\$550+gst

NUTRITIONAL CONSULTANT

Welcome to YOU Package	\$350 + gst
YOUR Deluxe Nutritional Journey	\$575 + gst

NATUROPATHIC DOCTOR

Initial Visit	\$180
Follow Up or Acupuncture	\$85

TRADITIONAL CHINESE MEDICINE

Initial Visit	\$125
Initial Herbal or Nutritional Consulting Visit	\$85
Follow Up (60 minutes)	\$100
Follow Up (45 Minutes)	\$80

ORTHOTICS

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

Prices subject to change.