Fountain of Health CHIROPRACTIC and Massage

Welcome to Fountain of Health Chiropractic and Massage!

Dr. Karen Raiwet's Mission:

Live Pain Free! We will help you find your optimal health through joint manipulation, soft tissue therapy, exercise prescription, and diet and nutrition counselling.

Our Chiropractic fees are as follows: *(subject to change without notice)*

New Patient Exam including treatment: $100.00 (approximately 60 minutes)
Standard Appointment: $40.00 (approximately 15 minutes)
Extended Appointment: $55.00 (approximately 30 minutes)*
* Length of recommended appointment will be discussed during evaluation.

Chiropractic services and products available at Fountain of Health Chiropractic and Massage:

- Hands on manipulation or mobilizations
- Therapeutic laser
- Interferential current
- Soft tissue treatment
  - -Active Release Tecnhiques(ART)®
  - - Graston®
  - - Trigenics®
- Adeeva® Vitamins & Supplements
- Diet and nutrition consultations
- Superfeet® and Custom Orthotics
- Traumeel® homeopathic ointments, tablets & oral drops
- Medistik® topical analgesic

Cancellation Policy: 12 hour notice of cancellation is required. If no attempt is made to cancel or reschedule appointments by voicemail or e-mail *[info@fountainchiro.ca]*, a Cancellation Fee equal to the cost of the visit will be charged. Cancellation Fees are not covered by insurance.

Please arrive 5 minutes early for subsequent visits. Late patients will not have priority over patients who are present for their scheduled appointments. An effort will be made to accommodate you if you are late, but not at the expense of other patients.

Dated this _____day of _____, 20_____.

I, _____, hereby acknowledge and understand the Cancellation Policy and agree to pay Cancellation Fees if levied.

_____
Patient Signature

_____ _____ ☐ Number on back of Card
Credit Card Number Expiry (Do not record on this form)

#107 - 20 Northlands Way NE ⁞ Medicine Hat, AB ⁞ T1C 1Z2 ⁞ phone (403)529-5972 ⁞ fax (403)529-5973

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Consultation Admittance Form - Chiropractic

Last Name: _____ First Name: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:

How do you prefer to be contacted: ☐home phone ☐cell phone ☐work phone ☐email

Number at which a message can be left: ☐home phone ☐cell phone ☐work phone

Appointment reminders will be sent by e-mail, text message or by phone call. My preference is: ☐e-mail ☐text message Carrier: ☐Phone ☐None

Regardless of method of reminder, you are still responsible for attending your appointment and if no attempt has been made to reschedule, no-show fees will be charged as per the cancellation policy. _____ Initial

Age: _____ Birth Date (m/d/y): ___/___/_____ Sex: M/F Height: _____ Weight: _____

Occupation: _____ Alberta Health Care #: _____

Emergency Contact Name: _____ Phone: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Reason for appointment? _____

When did your condition begin? _____

Have you ever had similar problems? ☐Yes ☐No

Have you had X-rays, MRI or other tests for this condition? What tests and when?

_____

_____

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Name: _____

Is this condition related to:

Work? ☐Yes ☐No Has your employer been notified? ☐Yes ☐No

Motor vehicle accident? ☐Yes ☐No Date of injury:

Can you perform your daily home activities? ☐Yes ☐Yes, only with help ☐Not at all

Can you perform your daily work activities? ☐Yes ☐Yes, only with help ☐Not at all

Describe your stress level: ☐None ☐Mild ☐Moderate ☐High

Do you exercise? ☐Daily ☐Occasionally ☐Not at all

Please list any previous surgeries, illnesses, injuries (motor vehicle accident): _____

_____

_____

Have you had previous chiropractic care? ☐Yes ☐No

Doctor: _____ Date: _____

Family doctor name: _____

May we share the results of your examination and treatment plan with your family doctor? ☐Yes ☐No

May we share the results of your examination and treatment plan with our massage therapist if you are also seeking massage treatment? ☐Yes ☐No

List ALL medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.) _____

_____

How did you hear about us? ☐ad ☐sign ☐referral by whom: _____

☐other _____

I understand that Alberta Health Care coverage for chiropractic care no longer covers any portion of the Doctor's fee schedule and that I am personally responsible for the balance of that fee.

_____ _____

Patient Signature: Date:

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HEALTH HISTORY QUESTIONNAIRE

Name: _____

Have you ever you ever been diagnosed or told you have any of the following?

Please circle the correct response.

1.	High blood pressure……..	Yes	No
2.	Hardening of the arteries (arteriosclerosis)……..	Yes	No
3.	Diabetes……..	Yes	No
4.	Tuberculosis……..	Yes	No
5.	Cancer, Where?.....	Yes	No
6.	Heart or blood diseases……..	Yes	No
7.	Bone spurs on the neck bones (cervical sprain)……..	Yes	No
8.	Whiplash injury (flexion-extension injury, cervical sprain)……	Yes	No
9.	Have you or any of your relatives ever suffered a stroke?.....	Yes	No
10.	Were you ever a smoker? From_____ To_____	Yes	No
11.	Do you take any medication on a regular basis?.....	Yes	No
12.	Visual disturbances (blurring, loss, double)……..	Yes	No
13.	Hearing disturbances (loss, ringing, other noise)……..	Yes	No
14.	Slurred speech or other speech problems……..	Yes	No
15.	Difficultly swallowing……..	Yes	No
16.	Dizziness……..	Yes	No
17.	Loss of consciousness, even momentary blackouts……	Yes	No
18.	Numbness, loss of sensation, strength/weakness in the face, fingers, hands, arms, legs or any other body parts…… Please indicate type and location on next page	Yes	No
19.	Sudden collapse without loss of consciousness……..	Yes	No
20.	Have you ever had any fractures?.....	Yes	No
21.	Have you ever been hospitalized? Why?.....	Yes	No

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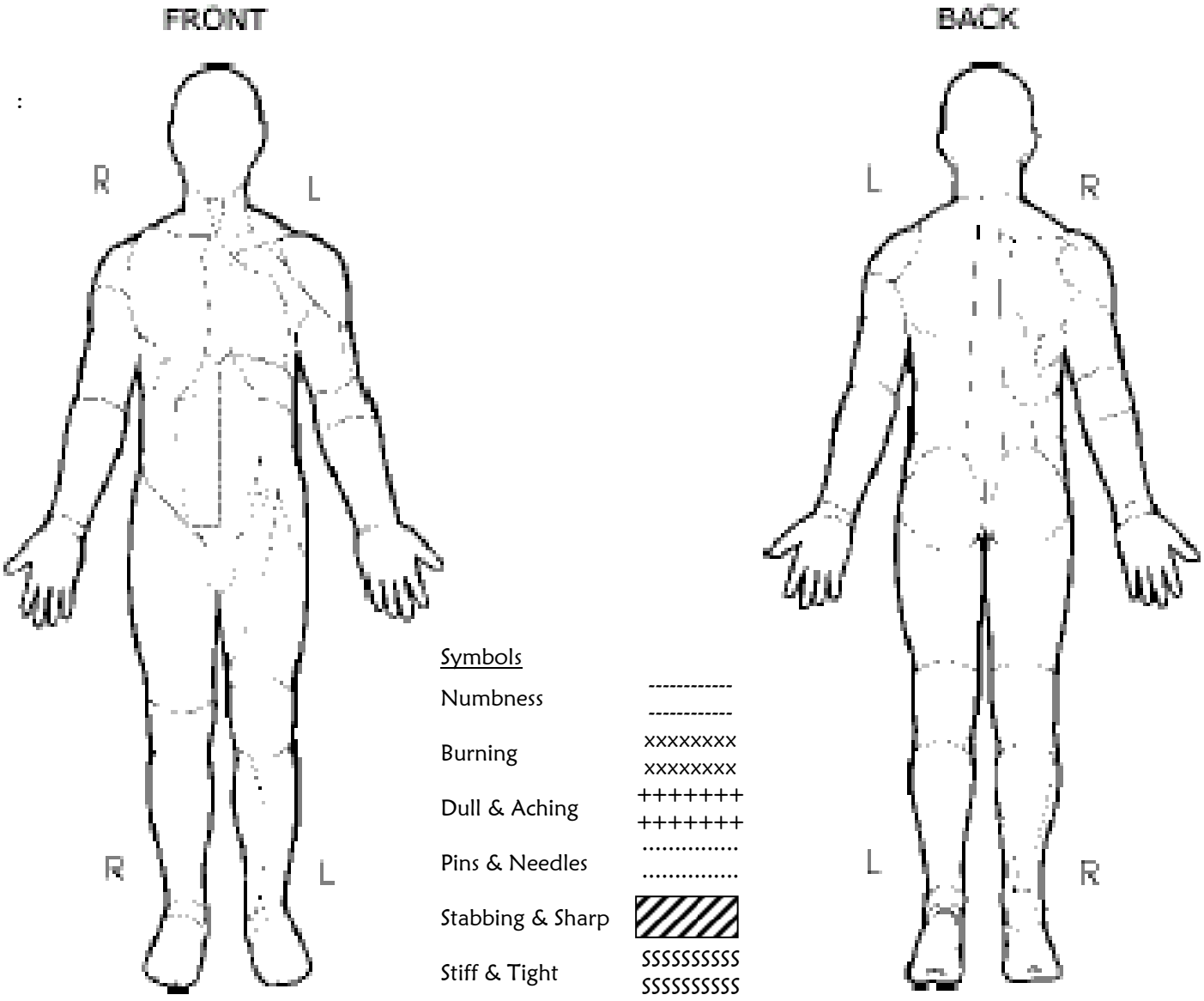
Name: _____

In the diagrams provided below, please mark the areas on your body which you feel best represents the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below.

:



Symbols

Numbness	---------- ----------
Burning	xxxxxxxx xxxxxxxx
Dull & Aching	+++++++ +++++++
Pins & Needles	....
Stabbing & Sharp	
Stiff & Tight	SSSSSSSSS SSSSSSSSS

Also, in order to complete the picture, please draw in your face.

Indicate the severity of the pain by circling a number.

| 0 1 2 3 4 5 6 7 8 9 10 |

No Pain Extreme Pain

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Name: _____

Health Status Survey – Please check (√)any conditions or symptoms presently causing you problems or have been a problem to you in the past.

Present	Past	GENERAL SYMPTOMS
_	_	Loss of consciousness
_	_	Blackouts
_	_	Headache
_	_	Fever
_	_	Sweats
_	_	Fainting
_	_	Dizziness
_	_	Clumsiness
_	_	Convulsions
_	_	Loss of sleep
_	_	Numbness, pain or tingling
_	_	Nervousness
_	_	Loss of weight

Present	Past	MUSCLES & JOINTS
_	_	Stiff neck
_	_	Back ache
_	_	Swollen joints
_	_	Painful tailbone
_	_	Foot trouble
_	_	Shoulder pain
_	_	Arm/Forearm pain
_	_	Elbow pain
_	_	Wrist pain
_	_	Hand pain
_	_	Arthritis
_	_	Weakness or loss of strength

Present	Past	E.E.N.T
_	_	Blurred vision
_	_	Failing vision (one/both eyes)
_	_	Crossed eyes
_	_	Double vision
_	_	Eye pain
_	_	Deafness
_	_	Earache
_	_	Ringing, buzzing, any noise in the ears
_	_	Asthma
_	_	Frequent colds
_	_	Sinus infection
_	_	Enlarged glands
_	_	Enlarged thyroid
_	_	Slurred or other speech problems
_	_	Difficulty swallowing

Present	Past	RESPIRATORY
_	_	Chronic cough
_	_	Spitting up phlegm
_	_	Spitting up blood
_	_	Chest pain
_	_	Difficulty breathing

Present	Past	CARDIOVASCULAR
_	_	Bleeding disorder
_	_	High blood pressure
_	_	Pain over heart
_	_	Stroke
_	_	Hardening of arteries
_	_	Varicose veins
_	_	Swelling of ankles
_	_	Poor circulation
_	_	Heart of blood disease
_	_	Angina

Present	Past	GENTOURINARY
_	_	Trouble urinating
_	_	Blood in urine
_	_	Kidney infection
_	_	Bed wetting
_	_	Prostate trouble

Present	Past	G.U. FOR WOMEN
_	_	Painful menstruation
_	_	Excessive flow
_	_	Hot flashes
_	_	Irregular cycle
_	_	Cramps or backache
_	_	Vaginal discharge
_	_	Swollen breasts
_	_	Lumps in breasts

Present	Past	SKIN
_	_	Rashes, Itching
_	_	Bruise easily
_	_	Dryness
_	_	Boils
_	_	Hives (allergy)

Present	Past	GASTROINTESTINAL
_	_	Poor appetite
_	_	Indigestion
_	_	Excessive hunger
_	_	Belching or gas
_	_	Nausea
_	_	Vomiting (blood?)
_	_	Pain over stomach
_	_	Constipation
_	_	Diarrhea
_	_	Hemorrhoids-(piles)
_	_	Jaundice
_	_	Gall bladder trouble
_	_	Intestinal worms
_	_	Ulcer
_	_	Diabetes

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