

Shephard Health

Suite 200, 1228 Kensington Road NW

Calgary, Alberta T2N 3P7

Phone: (403) 543-7499

Fax: (403) 543-7497

www.shephardhealth.com

Patient Information

Date: _____

Surname: _____

First Name: _____

Middle Initial: _____

Date of Birth (M/D/Y) _____ Age: _____

Sex: M F

Address: _____

City: _____ Province: _____ Postal Code: _____

*Alberta Health Care Number _____

Phone Numbers: Area Code Number Extension

Home _____ _____ _____

Phone (bus): _____ _____ _____

Phone (cell): _____ _____ _____

Email Address: _____

Automated Reminders: 1 day before 2 days before

E-mail: _____

Referral:

Personal Referral _____

Internet

Doctor Referral _____

Phone Book

Physiotherapist _____

Walk-In

Massage Therapist _____

Other: (please specify) _____

Family Doctor (Required): _____

Business Employer: _____ Type of Work: _____

Do you have Extended Health Coverage? Yes No

Insurance Company: _____

Motor Vehicle Accident (if applicable)

Are you seeking treatment for a Motor Vehicle Accident? (circle) Yes / No

Date of Motor Vehicle Accident: _____

Have you seen another practitioner in regards to this accident? (circle) Yes / No

Type of Practitioner: (circle) Physiotherapist / Chiropractor / Medical Doctor

Name of Practitioner: _____ Date of Assessment: _____

Insurance Company: _____ Phone Number: _____

Name of Claim Worker: _____ Claim #: _____

Current Health Condition

Purpose of this Appointment: _____

Major Complaint: _____

Explain How Complaint Occurred: _____

When Did This Condition Begin: _____

Condition Has Persisted For: Days Weeks Months Years

Condition Developed From: Auto Accident Work Injury Other Injury _____

Symptoms: Came on Suddenly Come & Go

What Activities Make Condition Better? _____

What Activities Make Condition Worse? _____

Symptoms are BETTER in: AM Midday PM

Symptoms are WORSE in: AM Midday PM Do not change with time of day

Have you ever had this condition before? No Yes, when _____

Other doctors seen for this condition: _____

Describe Other Complaints Involving: Neck/Head: _____

Mid-Back/Shoulders/Arms: _____

Low-Back/Hips/Legs: _____

Medications you are presently taking: _____

For what conditions: _____

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

SHADE OR CODE AREAS:

P – pain N – numbness S – spasms T – tenderness

U – unable P – painful D – difficult L – limited N – normal

- | | |
|----------------------------------|--------------------|
| ____ Coughing or Sneezing | ____ Kneeling |
| ____ Getting In Or Out of Car | ____ Balancing |
| ____ Turning over in Bed | ____ Dressing Self |
| ____ Walking Short Distances | ____ Sleeping |
| ____ Standing More than 1 Hour | ____ Stooping |
| ____ Sitting at Table | ____ Gripping |
| ____ Lying on Back | ____ Pushing |
| ____ Lying Flat on Stomach | ____ Pulling |
| ____ Lying on Side w/ Knees Bent | ____ Reaching |
| ____ Bending over Forward | ____ Sex Activity |
| ____ Climbing | |

Previous Chiropractic Care: _____

All Accidents or Falls: _____

Surgeries and Operations: _____

Hospitalizations: _____

Date of Last Spinal X-Rays: _____ Where? _____

Women: Are You Pregnant? Yes No Date Onset Last Cycle: _____

Past Health History

CHECK ANY DISEASES YOU HAVE HAD:

- | | | |
|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Influenza |

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

CARDIO-VASCULAR

- Blood Pressure Problems
- Heart Problems
- Lung Problems/Congestion
- Stroke
- Chest Pains

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostrate/Sexual Dysfunction

NERVOUS SYSTEM

- Nervous
- Numbness
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

DIGESTIVE TRACT

- Nausea
- Heartburn
- Gas/Bloating after Meals
- Constipation
- Diarrhea
- Bowel Infections
- Weight Trouble

EYE/EAR/NOSE/THROAT

- Vision Problems
- Sore Throat
- Stuffed Nose and Sinuses
- Hearing Difficulty
- Ear Aches

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Headaches
- Fever

GENITO-URINARY

- Bladder Trouble
- Painful Urination
- Excessive Urination

EXERCISE (check one)

- none o moderate o daily

What? _____

FAMILY HISTORY (For example, Cancer/Diabetes/ Heart Problems/Back or Neck Problems)

Father: _____
 Mother: _____
 Brothers: _____

HABITS

- Smoking: pks/day: _____
- Drinking: alcohol/wk: _____
- Coffee: cups/day: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**Preventative Care**). These are the three types of care. As your doctor will weigh your needs and desires when recommending your schedule of care, please check the type of care desired so that we may be guided by your wishes whenever possible.

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Relief Care | <input type="checkbox"/> Corrective Care | <input type="checkbox"/> Preventative Care | <input type="checkbox"/> Check here if you want the doctor to select the type of care appropriate for your condition. |
|--------------------------------------|--|--|---|

I confirm that the information I have provided in regards to my current condition and past health history are true to the best of my knowledge.

Signature: _____

Date: _____

Clinic Information

***Office Copy (Please Read and Sign for our Records)**

Office Hours

Monday 8 – 5pm	Tuesday 8 – 4pm	Wednesday 8 – 5 pm	Thursday 8 – 5pm	Friday 8 – 12pm
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Fee Schedule

Treatment Rates

Adjustment	\$34.00
Active Release Techniques (with or without adjustment)	\$59.00

Senior and Post-Secondary Student Rates

Adjustment	\$30.00
Active Release Techniques (with or without adjustment)	\$44.00

BioFlex Laser Therapy

30 minutes	\$45.00
45 minutes	\$72.50
60 minutes	\$90.00

PAYMENT IS DUE WHEN SERVICE IS RENDERED. Payment is accepted in the form of cash, cheque, debit card, Mastercard and Visa.

LASER APPOINTMENTS REQUIRE 24 HOURS NOTICE FOR CANCELLATION. FAILURE TO CANCEL WITHOUT REQUIRED NOTICE WILL RESULT IN THE PATIENT BEING BILLED FOR THE ENTIRE MISSED SESSION.

Credit Card Number and Expiry Date: _____

Extended Insurance

Most insurance companies are providing coverage for the portion paid by the patient.

***IMPORTANT: IT IS THE PATIENT'S RESPONSIBILITY TO CONFIRM EXTENDED COVERAGE WITH THEIR INSURANCE COMPANY.**

Please note that we DO NOT bill secondary insurance companies on your behalf, but we will be happy to assist you with your individual insurance forms.

At Work Injuries; Worker's Compensation Board (WCB)

Shephard Health is not an authorized WCB Provider. Please ask a member of our front desk staff for a referral to a WCB provider. If you still wish to be treated, payment is to be received at each office visit and a payment receipt will be provided to you. Shephard Health will not be held responsible if the fees are not reimbursed by WCB.

Signature

Date