Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

Chiropractic Intake Form

Personal Information: Date: _____

First Name: _____ Last Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Home Phone:_____ Cell: _____Work:_____

E-mail: _____ Alberta Health Care Number:_____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Sex: _____

Occupation: _____

Please check what type of reminder you would prefer: Email Reminder: ☐ Phone Call: ☐ None: ☐

Emergency Contact Information: Name:. _____ Phone: _____

How did you hear about Balanced Health and Sports Therapy? _____

Will your care be covered by? **Private ins**: ☐ Yes ☐ No **If Yes Who**: _____

Motor Vehicle Accident: ☐ Yes ☐ No **WCB:** ☐ Yes ☐ No **Veteran Affairs:** ☐ Yes ☐ No

PLEASE READ THOUROUGHLY AND SIGN WHERE INDICATED BELOW

Please note our cancellation policy: If less than 24 hours' notice is given to cancel your appointment, your account will be charged the full price of the appointment.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE ON ALL MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOURS NOTICE.

_____ _____

SIGNATURE of Patient (or parent/guardian) **DATE**

Please complete the questionnaire. Your answers will help determine if Chiropractic treatments can help you. If we do not believe your condition will respond satisfactory, we will not accept your case.

Health Information:

Reason for consulting Balanced Health & Sports Therapy: _____

Have you ever had Chiropractic Care: ☐ Yes ☐ No When: _____

By whom: _____ for what condition: _____

List all surgical operations and years: _____

List all the medication(s) you are currently taking:_____

_____

_____

List all the vitamin(s) and or supplement(s) you are currently taking:_____

_____

_____

Have you ever been in an auto accident: ☐ Yes ☐ No When: _____

Accident details: _____

Have you had any other personal injuries or accidents: _____

Have you had any x-rays: ☐ Yes ☐ No Where:_____ When:_____

Do you sleep well: ☐ Yes ☐ No What position do you sleep in:_____

Do you exercise regularly ☐ Yes ☐ No, if yes explain

_____

_____

Do you have any diagnosed medical conditions? ☐ Yes ☐ No, if yes explain

_____

_____

Date of last physical examination:_____ Medical Doctor:_____

Date of last dental examination:_____ Dentist:_____

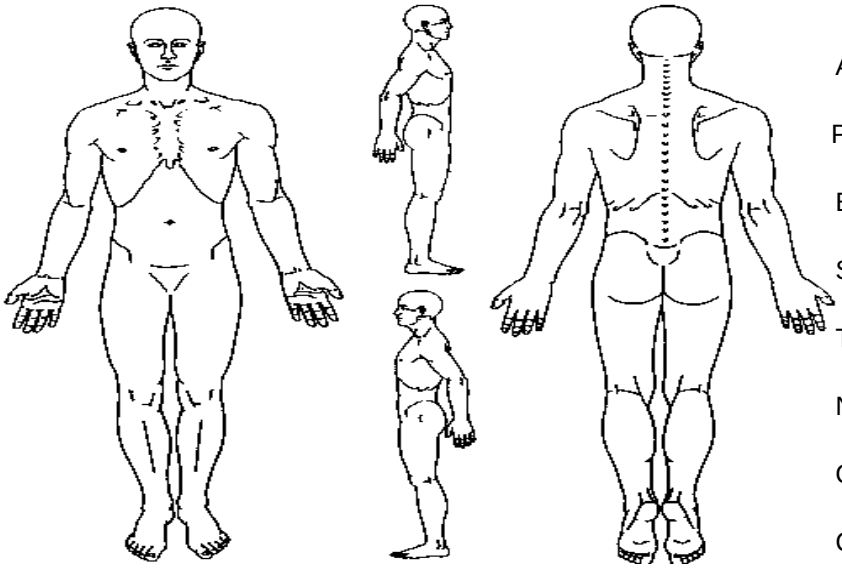
Describe what work related activities you do on a daily basis: (ex: lifting, typing, prolonged standing)

_____

Balanced Health and Sports Therapy

Chiro ● Physio ● Massage

MARK THE AREA(S) OF THE DIAGRAM WHERE YOU FEEL THE DESCRIBED SENSATION.



ACHING: **A**

PINS/NEEDLE: **P**

BURNING: **B**

STABBING: **S**

TIGHT/STIFF: **T**

NUMBNESS: **N**

OTHER: _____+ + + + +

COMMENTS _____

FAMILY HEALTH - Many health problems are a result of hereditary spinal weakness and have a tendency to occur in families. Please fill in the following chart.

Family	Age	Health Problems
Father		
Mother		
Brother / Sister		
Children		

Health Conditions:
Please **circle** any conditions that are presently causing you a problem. Please **check** those conditions which have been a problem in the past.

General Symptoms
- ☐Fever
- ☐Sweats
- ☐Fainting
- ☐Loss of sleep
- ☐Fatigue
- ☐Nervousness
- ☐Loss of weight

Respiratory
- ☐Chronic Cough
- ☐Spitting up phlegm
- ☐Spitting up blood
- ☐Chest pain
- ☐Difficulty breathing

Genitourinary
- ☐Frequent urination
- ☐Painful urination
- ☐Blood in urine
- ☐Pus in urine
- ☐Prostate trouble
- ☐Urine control

Neurological
- ☐Visual disturbance
- ☐Dizziness
- ☐Convulsions
- ☐Headache
- ☐Mood changes
- ☐Coordination

Cardiovascular
- ☐Rapid beating heart
- ☐Slow beating
- ☐High blood pressure
- ☐Low blood pressure
- ☐Pain over heart
- ☐Hardening of arteries
- ☐Poor circulation

Gastrointestinal
- ☐Poor appetite
- ☐Difficult digestion
- ☐Nausea
- ☐Vomiting
- ☐Vomiting blood
- ☐Constipation
- ☐Colitis

E.E.N.T
- ☐Eye pain
- ☐Deafness
- ☐Nosebleeds
- ☐Hoarseness
- ☐Asthma
- ☐Sinus infection
- ☐Enlarged glands

Muscle & Joint
- ☐Stiff neck
- ☐Backache
- ☐Neck pain
- ☐Swollen joints
- ☐Foot trouble
- ☐Pain in shoulders

For Women Only
- ☐Painful menstruation
- ☐Hot flashes
- ☐Irregular Cycle
- ☐Cramps or backache
- ☐Vaginal discharge
- ☐Lumps in breast
- ☐Menopause

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature

Graston Technique® Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning Graston Technique, and sign below. If you have any questions, please speak with your clinician.

1. Do you bruise easily? ☐Yes ☐No
2. Do you bleed for a long period of time after you cut yourself ☐Yes ☐No
3. Are you taking blood thinners or anticoagulants? ☐Yes ☐No
4. Do you take aspirin on a regular basis? ☐Yes ☐No
5. Do you take cortisone on a regular basis? ☐Yes ☐No
6. Have you ever had inflamed veins or blood clots? ☐Yes ☐No
7. Do you have surgical implants in your body? ☐Yes ☐No
8. Do you have diabetes or kidney disease? ☐Yes ☐No
9. Do you currently have any infections? ☐Yes ☐No
10. Do you have uncontrolled high blood pressure? ☐Yes ☐No

Graston Technique (GT) is an instrument-assisted variation of traditional cross fiber or transverse friction massage. The GT instruments consist of six stainless steel tools of various sizes and contours. GT is a form of treatment used to “break up” or “soften” scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

Graston Technique is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

Graston Technique has several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. Graston Technique Instrument Assisted Soft-Tissue Manipulation.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition, high weight exercises.
6. Ice therapy.
7. Stretching/rehabilitation exercise.

All components of Graston Technique have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Patient Name: _____ Date: _____

Signature of Patient (or Parent/Guardian): _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
INFORMED CONSENT FOR ACUPUNCTURE CARE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits
Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks
The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy
The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives
Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.
Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have read this form and discussed with the chiropractor the assessment of my condition and the treatment plan. I Understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to acupuncture treatment as proposed to me.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

1519 – 19th Street, Calgary, AB T2N 2K2
Phone: (403) 282-0880 Fax: (403)282-0898

Chiropractic and Physiotherapy Authorization to obtain medical records.

To: (record holder – completed by office)

_____

I, _____, do unconditionally authorize you to release to BALANCED HEALTH AND SPORTS THERAPY or anyone they shall in writing designate, any and all information they may so require in relation to my health, including, but without limitation all plain film radiographs including x-ray films, radiology reports, clinical and progress notes, nurses notes, reports on diagnostic test, secondary assessment, chiropractic and medical opinions and/or any other knowledge, information or data which you possess or have power to deliver, and for so doing kindly allow this to be your complete and sufficient authority.

_____

In consideration for your release of the information to my doctor, I hereby waive any patient privilege I may have regarding secrecy of chiropractic and medical information and I do release and discharge you and your assigns and/or successors of and from all claims for any damages resulting from the release of such information.

Date: _____

Signature: _____
Patient (or parent/guardian)

Witness: _____
Signature

Witness: _____
Name

Informed Consent & Questionnaire for Laser Therapy

Please answer the following questions and read the statements below concerning High Power Class IV SUMMUS Medical Laser Therapy. If you have any questions, please speak with your clinician.

1. Is there any chance that you may be pregnant? ☐Yes ☐No
2. Do you currently have (or have a history of) cancer? ☐Yes ☐No
3. Do you have a family history of cancer? ☐Yes ☐No
   Please list: _____
4. Do you have a pacemaker or electronic implant? ☐Yes ☐No
5. Are you taking any blood thinners (ex. Aspirin)? ☐Yes ☐No
6. Do you have very light sensitive skin (Photosensitive)? ☐Yes ☐No
7. Do you currently have any infections/fever? ☐Yes ☐No
8. Do you have Heart or Kidney disease? ☐Yes ☐No
9. Are you taking any of the following medications (please circle): ☐Yes ☐No
   Antihistamine, Coal Tar and derivatives, Antifungals, Contraceptives (birth control), Phenothiazines, Psoralens, Corticosteroids, Cortisone Sulfonamides, Sulfonylureas, Thiazide Diuretics (water pills), Tetracyclines, Tricyclic Antidepressants, High dose Vitamin A (ie. Accutane), Immunosuppressant drugs

Laser Therapy is a safe and effective therapy that is Health Canada cleared for the treatment of muscle and joint-related pain. Laser promotes the relaxation of spasm spasm/tension and promotes both increased tissues energy production and vasodilatation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks; however, your specific results may vary. Adverse effects from laser therapy may occur from multiple sources, in most cases involving a hypersensitivity to light, preexisting medical condition, thermal effects, excessive pressure from the treatment probe and laser over-stimulation. Laser therapy can cause serious damage to the eye, therefore it is very important to wear the protective glasses that will be provided at all times during treatment. Although rare, the most common adverse effects to laser therapy are:

1. Temporary increase in pain during laser application
2. Temporary increase in pain in the following day after laser therapy
3. Mild bruising
4. Temporary dizziness
5. Reactions when photosensitizing drugs are used with laser therapy

Your clinician has been thoroughly trained and certified to identify and minimize risk of any adverse reaction.

I have read and understand the potential risk associated with Laser Therapy and agree to the treatment program outlined by my clinician.

Date Signed_____ Patient Name_____Patient Signature _____