LACOMBE CHIROPRACTIC

William Hilsabeck, D.C.

CONSULTATION ADMITTANCE FORM

PATIENT INFORMATION			
Last Name / First Name / MI		Birth Date (dd/mm/yy)	Age
Address		City, Province	Postal Code
Home Phone ( )	Cell Phone ( )	Work Phone ( )	Email
Occupation	Marital Status ☐ Single ☐ Married ☐ Common-Law ☐ Divorced ☐ Widowed		Sex ☐ M ☐ F
Referred by ☐ Internet ☐ Yellow Pages ☐ Family ☐ Friend Name of Family or Friend:		Alberta Health Care Number	
Is this a work-related Injury? ☐ Yes ☐ No Is this Related to a Motor Vehicle Accident? ☐ Yes ☐ No		If Yes, Give Date of Injury: If Yes, Give Date of Accident:	

IN CASE OF EMERGENCY		
Emergency Contact Name	Relationship to Patient	Phone ( )

FEES				
Fees	Adult	Senior (65+)	Child (under 18)	AISH
Initial Visit	$80	$60	$25	$10
Office Visit	$45	$40	$25	$10

INSURANCE

Direct billing is available to many insurance providers
Please inform us if you have insurance coverage to determine what options are available to you

AGREEMENTS

Financial Responsibility
I understand that I am financially responsible for all healthcare services and/or supplies received from Lacombe Chiropractic. I understand that direct insurance billing is a service provided as a courtesy, and if my insurance coverage does not cover my entire bill or is declined, I am responsible for any balance owing.

Assignment of Benefits
I authorize direct remittance of payment from all insurance benefits to Lacombe Chiropractic for all healthcare services and/or supplies provided to me by Lacombe Chiropractic. I authorize Lacombe Chiropractic to release any information required to process my claims.

Electronic Submission
I authorize Lacombe Chiropractic to submit insurance claims electronically on behalf of myself and my family.

_____ _____

Patient/Guardian signature *Date*

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a

damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

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 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 chiropractic treatment as proposed to me.

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

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

_____ Date: _____20____
Signature of Chiropractor

LACOMBE CHIROPRACTIC
William Hilsabeck, D.C.

Name:

HEALTH HISTORY

Main reason for your visit: ☐ Neck pain ☐ Back pain ☐ headache ☐ Other

If other, please describe:

When did it begin?

Progression: ☐ Worsening ☐ No Change ☐ Improving

Have you had any tests for this condition? ☐ X-rays ☐ MRI ☐ CT scan ☐ Other

If other, please describe:

Have you previously had any:

Similar problems? ☐ Yes ☐ No

Treatment? ☐ Yes ☐ No

Type of pain	☐ Sharp	☐ Dull	☐ Aching	☐ Shooting
Pain Pattern	☐ Acute	☐ Constant	☐ Chronic	☐ intermittent
Symptoms	☐ Stiffness	☐ Tingling	☐ Numbness	☐ Pins & Needles

Does this interfere with your

☐ Daily routine ☐ Work

☐ Sleep ☐ Recreation

Describe any other symptoms?

Have you had previous treatment for this?

☐ Yes ☐ No

How severe is your pain? Circle a number

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Extreme Pain**

Have you previously seen a chiropractor? ☐ Yes ☐ No

If yes who did you see?

Date:

Who is your medical doctor?
List all medications:

List any previous:

- Surgeries
- Illnesses
- Fractures/Injuries
- Motor Vehicle Accidents

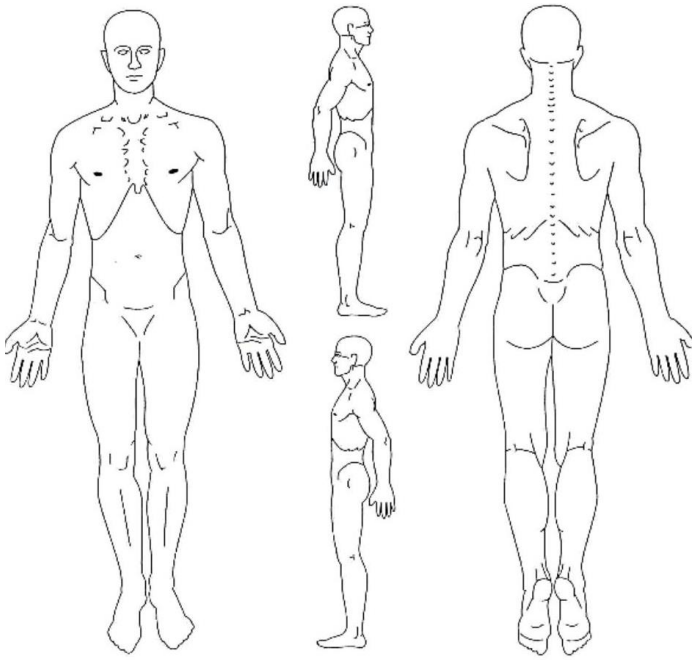
Circle area of concern

Mark with appropriate **letter**

Sharp **S**

Ache **A**

Pins/Needles **P**



LACOMBE CHIROPRACTIC
William Hilsabeck, D.C.

Name:

Check any conditions that you have experienced within the last **ONE MONTH**

GENERAL SYMPTOMS	**RESPIRATORY**	**EYES, EARS, NOSE, THROAT**
☐Fever	☐Chronic cough	☐Eye pain
☐Sweats	☐Spitting up phlegm	☐Double vision
☐Fainting	☐Spitting up blood	☐Ringing in ears
☐Sleep disturbance	☐Chest pain	☐Deafness
☐Fatigue	☐Wheezing	☐Trouble swallowing
☐Unexplained weight loss	☐Difficulty breathing	☐Hoarseness
	☐Asthma	☐Sinus infections
NEUROLOGICAL	**CARDIOVASCULAR**	**GENITOURINARY**
☐Visual disturbance	☐Rapid heartbeat	☐Frequent urination
☐Dizziness	☐High blood pressure	☐Painful urination
☐Fainting	☐Low blood pressure	☐Blood or pus in urine
☐Headache	☐Pain over heart	☐Kidney infection
☐Numbness	☐Hardening of arteries	☐Prostate trouble
☐Nerve pain	☐Swollen ankles	☐Uncontrollable urine flow
☐Poor coordination	☐Poor circulation	
☐Weakness	☐Palpitations	
	☐Cold hands or feet	
	☐Varicose veins	
GASTROINTESTINAL	**MUSCLE & JOINT**	**WOMEN ONLY**
☐Poor appetite	☐Neck pain	☐Painful Menstruation
☐Difficult digestion	☐Upper/Mid back pain	☐Irregular cycle
☐Heartburn	☐Low back pain	☐Complications with pregnancy
☐Ulcers	☐Shoulder pain	☐Pregnant? Y / N Week?
☐Nausea	☐Hip pain	
☐Vomiting	☐Arm or leg pain	
☐Irritable bowel symptoms	☐Pain or numbness down arms	
☐Blood in stool	☐Pain or numbness down legs	
☐Colitis	☐Spinal curvature	
	☐Fractures	
	☐Arthritis or degeneration	