

Healthquest Chiropractic & Natural Medicine
301, 1228 Kensington Rd NW, Calgary AB T2N 3P7
Phone: 403-270-0604 Fax: 403-270-0634

New Patient Intake Form

Name _____ Gender M / F

Address _____ Postal Code _____

Home Phone Number _____ Work _____ Mobile _____

Emergency Contact Name/Number _____

Date of Birth _____ Alberta Health Number _____

Email Address _____ Would you like an email reminder? Yes No

Current Medical Physician _____

Name of Clinic _____ Phone Number _____

Occupation _____ Is this a work related injury? _____

Collection of Personal Health Information

At Healthquest we collect from our patients basic contact information and medical information including health history, physical conditions and treatment notes. Medical information is used to properly diagnose and insure we provide safe treatments to our patients. Healthquest utilizes an Electronic Health Record system to store medical information.

All personal and health information is collected as authorized by the Health Information Act under Section 20.

If you have a concern about your personal information, please feel free to discuss these concerns with Dr. Miranda Moen directly.

Dr. Miranda Moen
Privacy Officer
Healthquest Chiropractic & Natural Medicine Ltd
301, 1228 Kensington Road NW
Calgary, AB T2N 3P7
drmoen@healthquestcalgary.com

Personal Health History

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely, feel that your condition will respond satisfactorily, we will not recommend treatment.

(Name) _____ (Date of Birth) _____ (Age) _____ (Today's Date) _____

Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

<table border="0"> <tr><td>O</td><td>F</td><td>C</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Muscle / Joint</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bursitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Foot trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hernia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low back pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Lumbago</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neck pain, stiffness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pain between shoulders</td></tr> <tr><td colspan="4">General</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chills</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Convulsions</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dizziness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting</td></tr> <tr><td><input type="checkbox"/></td><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rapid heartbeat</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Slow heartbeat</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Swelling of ankles</td></tr> <tr><td colspan="4">Genitourinary</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bed-wetting</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blood in urine</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent urination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Lack of kidney control</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney infection</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Painful urination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Prostate trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pus in urine</td></tr> </table>	O	F	C		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle / Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input 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type="checkbox"/></td><td><input type="checkbox"/></td><td>Hives or allergy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Itching</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Skin eruptions (rash)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Varicose veins</td></tr> <tr><td colspan="4">Pain or numbness in</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shoulders</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arms</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Elbows</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td>Spinal curvature</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Swollen joints</td></tr> <tr><td colspan="4">Respiratory</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chest pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic cough</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficult breathing</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Spitting up blood</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Spitting up phlegm</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Wheezing</td></tr> <tr><td colspan="4">Women only</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congested breasts</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cramps or backache</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Excess menstrual flow</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hot flashes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Irregular cycle</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Lumps in breast</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Menopause</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Painful menstruation</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Vaginal discharge</td></tr> </table>	O	F	C		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	Pain or numbness in				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	Respiratory				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	Women only				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congested breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<p><i>Check any of the following conditions you currently have or have had:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Cancer <input type="checkbox"/> Chicken pox <input type="checkbox"/> Cholera <input type="checkbox"/> Cold sores <input type="checkbox"/> Diabetes <input type="checkbox"/> Diphtheria <input type="checkbox"/> Eczema <input type="checkbox"/> Edema <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fever blisters <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Herpes <input type="checkbox"/> Influenza <input type="checkbox"/> Lumbago <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Miscarriage <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> 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Are you pregnant? Yes No
 If yes, how many months? _____
 How many children do you have? _____

Describe chiropractic problem: _____

How long have you had this condition? _____ Is it getting worse? Yes No

Does it bother your (check appropriate box): Work Sleep Other (please specify): _____

What seemed to be the initial cause: _____

Have you seen a chiropractor before? Yes No If yes, how long ago? _____

For what reason? _____

Are you under the care of a physician? Yes No If yes, for what reason? _____

Have you been hospitalized in the last 5 years? Yes No If yes, for major surgery? Yes No for serious injury? Yes No

Have you had any mental or emotional disorders? Yes No If yes, when?

Indicate the drugs do you now take? Birth control pills Tranquilizers Pain Killers Other (specify):

Do you wear: heel lifts? sole lifts? inner soles? area supports? negative heels? platform shoes?

What is the age of your mattress? Is it comfortable? uncomfortable? Do you use a bedboard? Yes No

How is most of your day spent? standing sitting walking other (specify):

Have you ever: Yes No If yes, briefly explain.

- had a broken bone? Yes No
- been hospitalized? Yes No
- had strains or sprains? Yes No
- used a cane, crutch or other support? Yes No
- been struck unconscious? Yes No
- been hospitalized for other than surgery? Yes No

- Do you:
- take minerals, herbs or vitamins? Yes No
 - think you need minerals, herbs or vitamins? Yes No
 - have any drug allergy? Yes No

- When did you last have:
- | | Never | 0-6 mos. | 6-18 mos. | longer |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| - spinal x-ray? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - spinal examination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - physical examination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

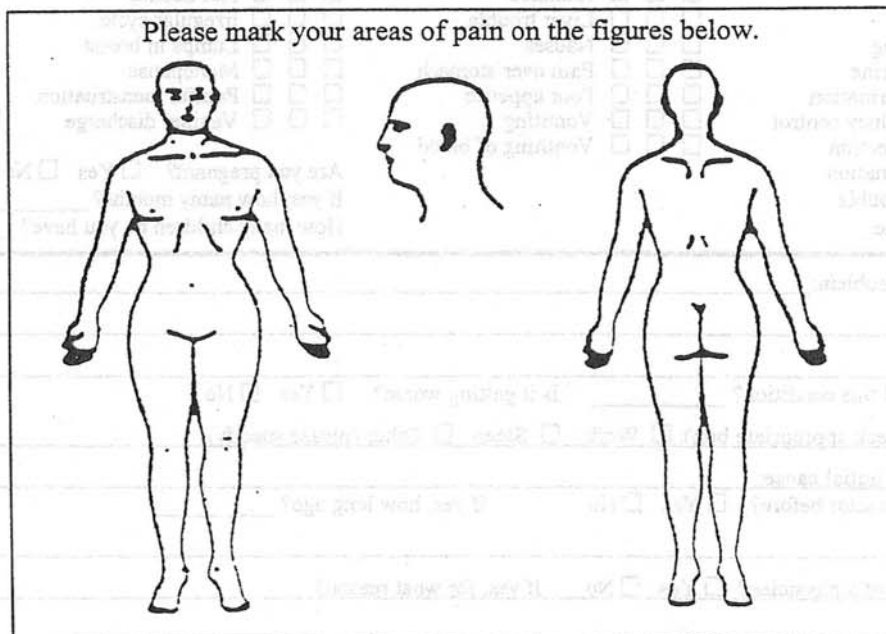
HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

FAMILY HEALTH HISTORY

Some health conditions are the result of hereditary spinal weaknesses. Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS



Consent Form

To Our Patients;

Anything discussed in this clinic will remain confidential.

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

(Signature)

(Date)

If additional information is requested:

I requested and received, in substantial detail, further explanation of the procedure or treatment. I was also given information about material risks of the procedure or treatment, and other alternative procedures or methods. I give permission and consent to the procedure or treatment.

(Signature)

(Date)

