



CHIROPRACTIC UPDATE AND/OR REASSESSMENT FORM

First Name: _____ Last Name: _____

Preferred Name: _____ Prefix/Title: _____

Cell: _____ Home: _____

Address: _____
(Street) (City, Province) (Postal Code)

Date of Birth: _____ Gender: _____ Sex: M / F
(DD / MM / YYYY)

Alberta Health Number: _____ Guardian: _____

Occupation: _____ Employer: _____

Emergency Contact Phone: _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____

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Family Doctor: _____

Family Doctor Phone: _____ Family Doctor Email: _____

Name of referring professional: _____

Referring Prof. Phone: _____ Referring Prof. Email: _____

Please provide the following information for our records.

Are you seeking care due to a motor vehicle collision, work-related injury or WCB claim?

☐ No ☐ Yes

My present symptoms are ...

How have these symptoms affected your activities and function in daily life?

How intense would you rate your pain on the 1-10 scale (0 = no pain)?

0 1 2 3 4 5 6 7 8 9 10

What are you currently doing to improve this condition that you are seeking relief for? Is it helping?

Chiropractic Adjustments:

What is the approximate date of your last chiropractic adjustment? _____

Your last chiropractic treatment was provided by:

Name of doctor: _____ Name of clinic: _____

Since your last chiropractic treatment (here or elsewhere), please describe any of the following events with dates (answer N/A if not applicable).

☐ Recent falls/injuries _____

☐ Recent surgeries _____

☐ Motor Vehicle Accidents _____

☐ Concussions _____

Communication:

Appointment Notifications and Reminders:

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

Email

☐ Email 2 days prior to appointment

Text Message (SMS)

☐ Text Message (SMS) 2 hours prior to appointment

News and Special Promotions

☐ Yes, I would like to receive clinic updates and health and wellness information from the Vibe team of practitioners. This is usually sent on a monthly basis.

Update/ReAssessment or Transfer - Consents**Accuracy of Information**

☐ I certify that the above medical information is correct to my knowledge. - Required

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree. - Required

Cancellation, No Show and Late Arrival Policies

A credit card is required to reserve appointments of 1 hour (or greater) in length.

When an appointment is scheduled, it is reserved exclusively for you. If you cancel or miss the appointment without sufficient notice, it prevents another individual from booking that time slot resulting in lost opportunity for the therapist to provide their service and generate income. In our desire to be effective and fair to all clients, the following policies are honoured:

CANCELLATIONS: A FULL 24-hour advance notice is required when cancelling an appointment. If you are unable to give 24 hours advance notice you will be charged 50% of the booked service fee.

NO SHOWS: All no shows will be charged 50% of the booked service fee.

Phone calls and emails are time stamped therefore notifications delivered in this manner are subject to our Cancellation and No Show policies.

Cancellation and No Show fees will be automatically charged to your credit card.

LATE ARRIVALS: If you arrive late for your scheduled appointment, your appointment will still end at the scheduled time and you will be charged the full fee for the booked service. It is not the duty of the therapist to accommodate missed time and cannot be demanded.

☐ I confirm that I have read, fully understand, agree to the above policies, and agree to pay the fees associated with the service booked. I authorize Vibe Health & Spine to charge my credit card for any treatment that is not cancelled at least 24 hours prior to the booked service. I certify that I am an authorized user of the credit card on file and will not dispute this scheduled transaction with my bank or credit card company as long as the transaction corresponds to the terms of this consent form. - Required

Signature: _____ Date: _____