



LASER INTAKE 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: _____

=====

Family Doctor: _____

Family Doctor Phone: _____ Family Doctor Email: _____

Name of referring professional: _____

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

=====

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

☐ No

☐ Yes

How did you hear about our practice? Which of our chiropractors were you referred to?

What problem or complaint brings you in to see us?

Where exactly is the pain/problem located?

Laser Intake Form:

What is the quality of the pain/symptom?

- | | | |
|--------------------------------|------------------------------------|---|
| ☐ Sharp | ☐ Tight | ☐ Dizzy/Light headed |
| ☐ Dull | ☐ Throbbing | ☐ Other |
| ☐ Achy | ☐ Pulsatile | ☐ Not Applicable |

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

Please answer the following in relationship to timing and pattern of your complaint:

- ☐ How long have you had this concern? _____
- ☐ What is the frequency? _____
(constant, daily, weekly, mornings, evenings, certain activities/positions, random)
- ☐ How often is it an issue? _____
- ☐ What relieves the pain? _____
- ☐ What worsens the pain? _____

Have you had any accidents/traumas that may have caused or contributed to this problem?

Other notes you'd like to add regarding this symptom or pain quality (include if it radiates anywhere or affects other conditions):

Please rate the effect of this condition(s) on your activities of daily living:

- ☐ 0 - No pain/interference with activities.
- ☐ 1 - Concern for certain motions/postures.
- ☐ 2 - An annoyance/not pain.
- ☐ 3 - Slight pain some days.
- ☐ 4 - Occasional moderate pain, doesn't dictate my choice of activities.
- ☐ 5 - Moderate pain most days. Pain may dictate my choice of activity.
- ☐ 6 - Constant Moderate Pain and WILL dictate my choices of activities.
- ☐ 7 - Severe pain most days but achieves relief with rest.
- ☐ 8 - I can't do anything without severe pain.
- ☐ 9 - Only choice of activity is in seeking relief.
- ☐ 10 - I can't perform any activities. I have severe pain all the time.

What past and/or current treatments have you pursued for this complaint and what have been the results?

Any other symptoms in any of these areas (please check and describe)?

- | | |
|---|-------------------------------------|
| ☐ Head _____ | ☐ Arms _____ |
| ☐ Neck _____ | ☐ Legs _____ |
| ☐ Mid back _____ | ☐ Eyes _____ |
| ☐ Low back _____ | ☐ Jaw _____ |
| ☐ Other _____ | |

Health History Questionnaire:**Have you ever been diagnosed with (told that you have) the following (check N/A if none apply):**

- | | | |
|---|--|---|
| ☐ High blood pressure | ☐ Whiplash injury | ☐ Slurred speech/Speech problems |
| ☐ Hardening of the arteries | ☐ Suffered a stroke | ☐ Difficulty swallowing |
| ☐ Diabetes | ☐ A relative has had a stroke | ☐ Dizziness |
| ☐ Tuberculosis | ☐ You are/were a smoker | ☐ Loss of consciousness, even momentary blackouts |
| ☐ Cancer | ☐ You take medication on a regular basis | ☐ Numbness/Loss of sensation/Loss of strength/Weakness in Face/Fingers/Hands/Arms/Legs or any other part of the body |
| ☐ Heart and blood pressure | ☐ Visual disturbances (blurring, loss, double vision) | |
| ☐ Bone spurs on the neck bones (cervical sprain) | ☐ Hearing disturbances (loss, ringing, other noise) | ☐ Sudden collapse without loss of consciousness |
| | | ☐ Not applicable (N/A) |

Please elaborate for any conditions checked off above (include dates of diagnosis, current state of condition and other relevant details).

Systems Review:

*Check the box for anything you are currently experiencing or have experienced in the past.
Leave blank any condition that you do not have.*

General Symptoms:

- | | | |
|-----------------------------------|---|--------------------------------------|
| ☐ Fever | ☐ Sleep disturbances | ☐ Weight loss |
| ☐ Sweats | ☐ Fatigue | ☐ Weight Gain |
| ☐ Fainting | ☐ Nervousness | |

Neurological:

- | | | |
|--|--------------------------------------|---|
| ☐ Visual Disturbances | ☐ Convulsions | ☐ Neuralgia (nerve pain) |
| ☐ Dizziness | ☐ Headaches | ☐ Poor Coordination |
| ☐ Fainting | ☐ Numbness | ☐ Weakness |

Systems Review (cont'd):**Eyes, Ears, Nose & Throat:**

- | | | |
|--|---|--|
| ☐ Eye Pain | ☐ Nosebleeds | ☐ Nasal Drainage |
| ☐ Double Vision | ☐ Trouble Swallowing | ☐ Enlarged Glands |
| ☐ Ringing in the Ears | ☐ Hoarseness | |
| ☐ Deafness | ☐ Sinus Infection | |

Respiratory:

- | | | |
|---|---|---------------------------------|
| ☐ Chronic Cough | ☐ Chest Pain | ☐ Asthma |
| ☐ Spitting up Phlegm | ☐ Wheezing | |
| ☐ Spitting up Blood | ☐ Difficulty Breathing | |

Cardiovascular:

- | | | |
|--|--|--|
| ☐ Rapid Beating Heart | ☐ Pain over the Heart | ☐ Cold Hands, Cold Feet |
| ☐ Slow Beating Heart | ☐ Hardening of the Arteries | ☐ Varicose veins |
| ☐ High Blood Pressure | ☐ Swollen Ankles | |
| ☐ Low Blood Pressure | ☐ Poor Circulation | |

Muscle & Joint:

- | | | |
|--|--|---|
| ☐ Neck Pain | ☐ Knee Pain | ☐ Spinal Curvature |
| ☐ Low Back Pain | ☐ Foot Pain | ☐ Arthritis |
| ☐ Arm Pain | ☐ Pain/Numbness in Arm/Legs | ☐ Fractures |
| ☐ Shoulder Pain | ☐ Pain between Shoulders | |
| ☐ Leg Pain | ☐ Swollen Joints | |

Genitourinary:

- | | | |
|---|---|--|
| ☐ Frequent Urination | ☐ Puss in Urine | ☐ Uncontrollable Urine Flow |
| ☐ Painful Urination | ☐ Kidney Infection | |
| ☐ Blood in Urine | ☐ Prostate Trouble | |

Gastrointestinal:

- | | | |
|--|---------------------------------------|---|
| ☐ Poor Appetite | ☐ Nausea | ☐ Blood in Stools |
| ☐ Difficult Digestion | ☐ Vomiting | ☐ Gallbladder/Jaundice |
| ☐ Heartburn | ☐ Constipation | ☐ Colitis |
| ☐ Ulcers | ☐ Diarrhea | |

Systems Review (cont'd):**For Women Only:**

- | | | |
|---|--|--|
| ☐ Painful Menstruation | ☐ Hot Flashes | ☐ Irregular Cycle |
| ☐ Cramps or Back Pain | ☐ Nipple Discharge | ☐ Lumps in Breasts |
| ☐ Menopausal Symptoms | ☐ Birth Control Pills | ☐ Complication with Pregnancy |
| ☐ Currently Pregnant | ☐ Past C-section | ☐ Vaginal Birth |

Additional details to add, if needed, relating to the above symptoms or conditions:

List of Practitioners (Provide name of Practitioners in your health care team):

- ☐ Medical Doctor _____
- ☐ Dentist/Orthodontist _____
- ☐ Chiropractor _____
- ☐ Optometrist/Eye Specialist _____
- ☐ Massage Therapist _____
- ☐ Acupuncturist _____
- ☐ Naturopath/Homeopath _____
- ☐ Osteopath _____
- ☐ Physiotherapist _____
- ☐ Psychologist/Counsellor _____
- ☐ Exercise/Fitness Trainer _____
- ☐ Other _____

Lifestyle Habits:**What do you do for work?** _____**Does your work involve:**

- ☐ Sitting for long periods ☐ Standing for long periods ☐ Heavy Lifting ☐ Awkward positions for head/neck
☐ Lots of computer work ☐ High levels of stress ☐ All of the above

Do you wake rested? ☐ **Yes** ☐ **No****Do you feel fatigued during the course of a day?**
☐ **Often** ☐ **Sometimes** ☐ **Never**
Do you play or have you ever played these sports?

- | | | |
|---|--|---|
| ☐ Hockey | ☐ Golf | ☐ Weight Lifting |
| ☐ Soccer | ☐ Ringette | ☐ Tennis |
| ☐ Lacrosse | ☐ Skiing | ☐ Badminton |
| ☐ Baseball | ☐ Snowboarding | ☐ Squash |
| ☐ Gymnastics | ☐ Snowmobiling | ☐ Other |
| ☐ Horseback Riding | ☐ Track & Field | |
| ☐ Football | ☐ Running | |

Please list any falls, accidents, traumas, vehicle collisions or work related accidents you have had in the past or recently: _____

_____**Have you ever been knocked unconscious?**
☐ **Yes** ☐ **No** ☐ **Multiple times**
Have you ever been hospitalized?
☐ **No** ☐ **Yes (indicate reason)** _____
Have you ever broken a bone, had surgeries or operations?
☐ **No** ☐ **Yes (list)** _____
Check any of the following if you have them.

- | | | |
|---|---|---|
| ☐ Snoring | ☐ Many cavities in teeth | ☐ Can't see 3D at the movies |
| ☐ Grinding teeth | ☐ High Stress | |

Please reflect on your current sense of WELL-BEING, including physical, mental, emotional, social & spiritual condition. Use the scale to mark your answer (0 = worst I have ever been).

0 1 2 3 4 5 6 7 8 9 10

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.

Laser Intake Form - 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: _____