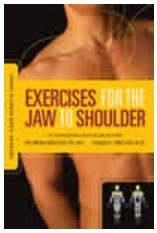
Patient Admittance Form



Kinetic Health™
Soft Tissue Management Systems

Dr. Brian Abelson DC, & Associates
Bay # 10, 34 Edgedale Drive NW.
Calgary, Alberta, Canada, T3A-2R4
Phone: 403-241-3772
Fax: 403-241-3846

Email kinetichealth@shaw.ca

Name: _____
(Family) (First) (Initial)

Sex: ☐ Male ☐ Female Marital Status: _____ Children: _____

Date of Birth: _____ Age: _____Height: _____ Weight: _____

Home Address_____

Postal Code: _____ Name of Spouse or Parent _____

Phone Number: Home_____ Work: _____

Email address:
_____

Please Note: Email addresses are strictly confidential and are never given out to other sources. We believe in a no spam policy. We use emails to confirm appointments, provide you with exercises, instructions for your care, health updates and clinical newsletters. It also provides you with a means of asking your practitioner questions when they are not able to answer phone calls while treating patients. You can choose to opt out of our email information system at any time.

Your Occupation:
_____

In case of emergency, who should we notify/phone:_____

Alberta Health Care Number **(Required)**:_____

Your Family Doctor **(Required)**:_____

Would you like to see a particular Physician? ☐ YES ☐ It does not matter
If YES: ☐ **Dr. Abelson** ☐ **An Associate**: _____

What is your chief complaint, or primary reason for coming to our clinic?
(Please provide an exact description).

Chief Complaints

- Describe the **onset** of this condition. Is your complaint related to a fall, an accident, or an auto accident? Please describe!

- How long have you had this condition (**Duration**)? What is its **frequency**?

- Do you have a **history** of similar conditions in the past?

- Is the condition getting:
  ☐ Worse
  ☐ Same
  ☐ Better
  ☐ Consistent
  ☐ Recurring

- How does the condition interfere with your work or activities of daily living?

- Is there a particular **time of day** when your condition is worse?

  ☐ Morning
  ☐ Afternoon
  ☐ Evening
  ☐ During the night
  ☐ After long periods of activity

- Is this an **auto accident case**, or have you recently been in an accident?
  ☐ YES (Please explain) ☐ NO

- Is this a **workman's compensation** case?
  ☐ YES ☐ NO

- How would you describe the **Character** of the pain that you are experiencing?

  ☐ Persistent
  ☐ Intermittent
  ☐ Aching/Throbbing
  ☐ Tingling
  ☐ Numbness
  ☐ Burning
  ☐ Shooting
  ☐ Radiating pain
  ☐ Other

- What **aggravates** your condition?

- What relieves (**alleviates**) your condition?

- What types of treatment have you received for this condition? Please list and detail.

- Please provide the names of other doctors that you have seen for this condition?

- What was the duration and frequency of previous treatment for this condition?

- What were the **results** of previous treatments:

  ☐ Poor
  ☐ Fair
  ☐ Good
  ☐ Excellent
  ☐ Other, please explain.

General Systems Review

Respiratory

☐ Allergies
☐ Asthma
☐ Bronchitis
☐ Chest Pain
☐ Cough
☐ Emphysema
☐ Frequent Colds
☐ Hay fever
☐ Pneumonia
☐ Smoker
☐ Trouble Swallowing

Skin

☐ Acne
☐ Boils
☐ Color changes
☐ Dermatitis
☐ Eczema
☐ Fungal Infection
☐ Drynes
☐ Herpetic Infection
☐ Itching
☐ Lumps
☐ Pain
☐ Polyps
☐ Psoriasis
☐ Rashes
☐ Scars
☐ Singles
☐ Steroid Therapy
☐ Swelling

Vision

☐ Redness
☐ Glaucoma
☐ Light Sensitivity
☐ Blurred Vision
☐ Cataracts
☐ Double Vision
☐ Dyslexia
☐ Tearing

Cardiovascular

☐ Angina
☐ Ankle swelling
☐ Arrhythmia's
☐ Arteriosclerosis
☐ Blood Clots
☐ Chest pain
☐ Cold/ blue hands, feet
☐ Low Blood Pressure
☐ Noticed heart racing
☐ Shortness of breath
☐ Rheumatic
☐ Pounding Sensation
☐ Heart Attack

Hair

☐ Color Changes
☐ Recent Loss

Ears

☐ Buzzing
☐ Discharges
☐ Dizzy
☐ Infection
☐ Ringing
☐ Tinnitus

Head

☐ Concussion
☐ Headaches
☐ Insomnia
☐ Memory Decline
☐ Concentration

Mouth/Throat

☐ Bleeding
☐ Gum Disease
☐ Dental Decay
☐ Sore Throat
☐ Toothache

Gastro-intestinal

☐ Alternating diarrhoea & Constipation
☐ Appendicitis
☐ Appetite loss
☐ Black Stool
☐ Blood in Stool
☐ Constipation
☐ Chron's
☐ Colitis
☐ Diarrhoea
☐ Heart Burn
☐ Nausea
☐ Pain
☐ Digestive Disorders
☐ Gall Bladder Problem
☐ Gas and Bloating
☐ Irritable Bowel Syndrome
☐ Pain after Eating
☐ Poor appetite
☐ Stomach Cramps
☐ Stomach pain when upset
☐ Vomiting
☐ Ulcers

Urinary

☐ Bed Wetting
☐ Bladder and kidney infections
☐ Blood in Urine
☐ Burning
☐ Dribbling
☐ Hesitancy
☐ Incontinence
☐ Infections
☐ Kidney Stones
☐ Yeast Infection
☐ Decreased Force
☐ Decreased Frequency
☐ Increased Frequency

Vascular

☐ Anaemia
☐ Easy Bleeding
☐ Easy Bruising
☐ Hemorrhoids
☐ Cold Hands and Feet
☐ Leg pain after walking
☐ Raynauld's
☐ Swelling
☐ Thromophlebitis
☐ Varicose Veins

Musculoskeletal

☐ Arthritis
☐ Back Ache
☐ Disc Problems
☐ Fractures
☐ Gout
☐ Hernia
☐ Joint Pain
☐ Muscle Cramps
☐ Muscle Injury
☐ Stiffness
☐ Paralysis
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid
☐ Scoliosis

Neurological

☐ Alzheimer's
☐ Burning sensation
☐ Epilepsy
☐ Fainting
☐ Numbness
☐ Parkinson's
☐ Sciatica
☐ Seizures
☐ Tingling sensation
☐ Tremors

Endocrine

☐ Diabetic
☐ Hyperthyroid
☐ Hypothyroid
☐ Increased Thirst
☐ Water Retention
☐ Cold Intolerance
☐ Heat Intolerance
☐ Increased Sweating
☐ Increased Urine Output

Female Reproductive

☐ Pregnant ☐ NO
☐ YES Due-Date
☐ Birth Control Pills
☐ Discharges
☐ HIV
☐ Hysterectomy
☐ Lumps
☐ Menopause
☐ PMS
☐ Regular Period
☐ Bleeding Between Periods
☐ Decreased Sex Drive
☐ Fertility Problems
☐ Frequent Periods
☐ Increase Flow Duration
☐ Increase MenstrualFlow
☐ Painful Cycle
☐ Pelvic Inflammation
☐ STD

Male Reproductive

☐ Impotence
☐ Pus Discharge
☐ Rashes
☐ Testicular Pain
☐ Decreased Sex Drive
☐ Prostate Problems
☐ STD
☐ Trouble with Urination

Pain or Numbness

☐ Shoulders
☐ Arms
☐ Hands
☐ Hips
☐ Legs
☐ Knees
☐ Ankles
☐ Feet
☐ Tail bone
☐ Sciatica
☐ Swollen joints

Other

☐ Alcoholic
☐ Cancer
☐ Chemotherapy
☐ Depression
☐ Gout
☐ Hepatitis
☐ Night Sweats
☐ Steroid Therapy
☐ Surgery
☐ Multiple Sclerosis
☐ Radiation Therapy
☐ AIDS
☐ HIV Positive
☐ Recent Traumatic Event

Family History

☐ Arthritis
☐ Genetic Problems
☐ Auto immune condition
☐ Cancer
☐ High Blood Pressure
☐ Diabetes
☐ High Cholesterol
☐ Hypothyroidism
☐ Heart Attack
☐ Hyperthyroidism
☐ Stroke
☐ Vascular Problems

Childhood conditions

Check all the conditions that you have had:

☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Whooping Cough
☐ Scarlet Fever
☐ Diphtheria
☐ Rheumatic Fever
☐ Typhoid Fever
☐ Ear Infections
☐ Asthma
☐ Allergies

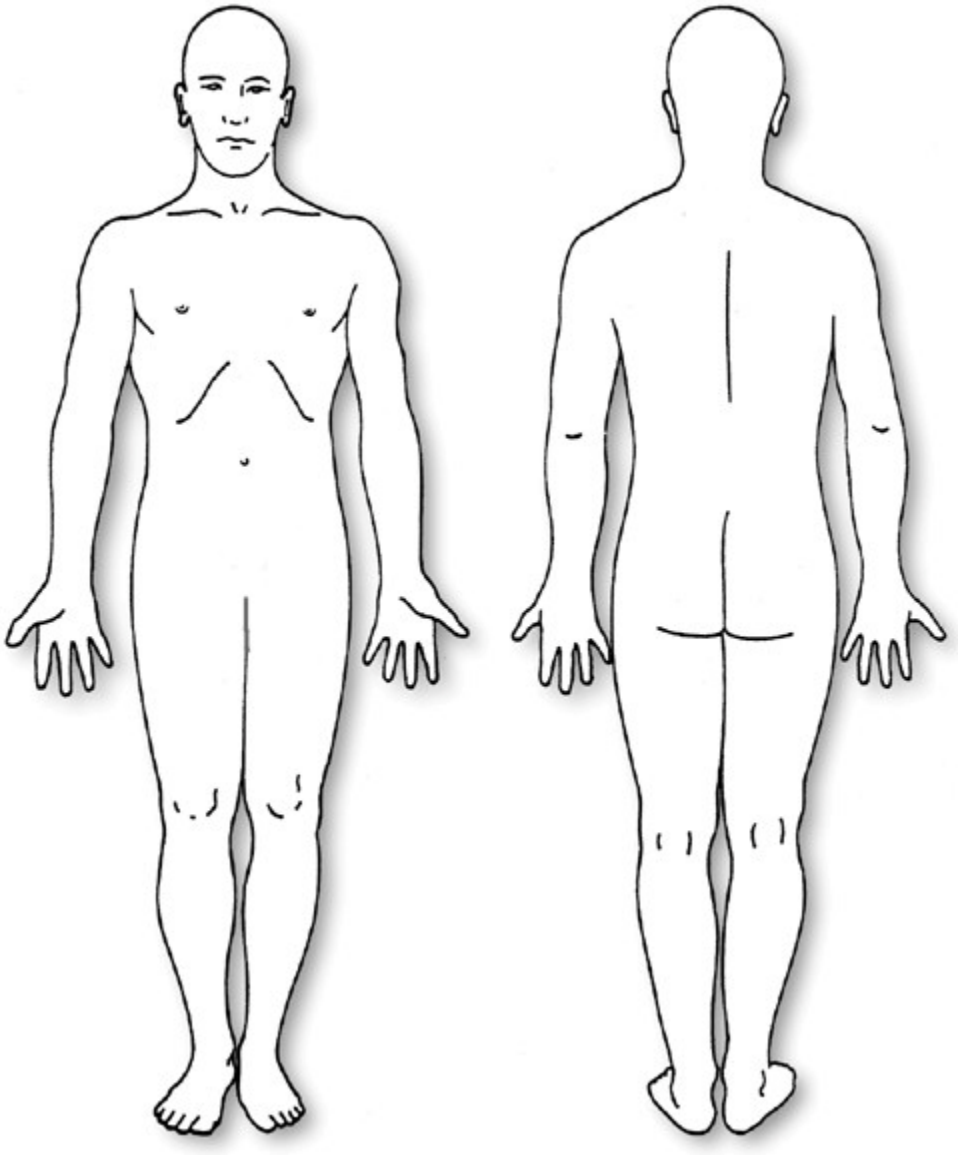
Additional Information

Medications: Are you on any medications? If so please list them.

Surgeries: Have you had any previous surgeries?

Other Information: Other relevant information pertaining to this case?

Pain Diagram



Please number the areas where you are experiencing pain or discomfort, according to the following pain scale.

Number Listing	Amount of pain or discomfort you are experiencing
0	No pain or discomfort.
1, 2, 3	The pain or discomfort is an annoyance.
4, 5, 6	The pain or discomfort interferes with activities.
7, 8, 9	The pain or discomfort prevents me from performing certain activities.
10	The pain or discomfort sends me to the emergency room.

Exercise and Life Style Related Questions:

Exercise:

How many days per week are you exercising?
☐ None
☐ 1-2 days per week
☐ 3-4 days per week
☐ 5 or more Days per week

How long do your workouts usually last?
☐ Up to 30 minutes
☐ Up to 45 minutes
☐ Up to 1 hour or more

Do you perform cardiovascular exercise on a regular basis? *

☐ Yes ☐ No

Do you perform stretching exercises on a regular basis? *

☐ Yes ☐ No

Do you lift weights or are you involved in weight training on a regular basis? *

☐ YES → ☐ Machines ☐ Free weights ☐ Both
☐ NO

Do you experience chest pain with mild exertion?

☐ Yes ☐ No

Do you experience unusual fatigue or shortness of breath during usual activities?

☐ Yes ☐ No

Do you experience dizziness, fainting or blackouts with mild exertion?

☐ Yes ☐ No

Have you experienced leg pain upon exertion?

☐ Yes ☐ No

Has your doctor said that you have a musculoskeletal disorder that could be made worse by physical activity?

☐ Yes ☐ No

Please Specify:

* Regular basis is defined as at least three times per week.

Sleep:

Circle hours of sleep per night

2-4, 4-6, 6-8, 8-10, 12+

☐ Usually awake feeling refreshed.

☐ Usually awake feeling tired.

☐ Often tired throughout the day.

Smoking:

Do you smoke, or have you smoked within the last six months?

☐ Yes ☐ No

If yes, do you understand smoking slows all healing processes to the point where full recovery may not be possible from injury?

☐ Yes ☐ No

Weight:

How do you feel about your present weight?

☐ My present weight is ideal for me.

☐ I need to lose 5-10 pounds.

☐ I need to lose 10-20 pounds.

☐ I need to lose more than 20 pounds.

☐ I need to gain weight.

Diet:

How would you rate your current dietary habits?

☐ Excellent ☐ Very Good ☐ Good ☐ Poor ☐ Very poor

Stress:

How would you rate your current level of stress?

Stress is defined as your individual response to environmental demands or pressures.

☐ Extreme stress

☐ High stress

☐ Moderate stress

☐ Low stress

What can we do for you...?

We want your experience at our clinic to be a good one. To help us achieve this goal, we need to ask just a few more questions.

1. **What would you like to achieve by coming to our clinic**
   Our primary goal is always to work toward the resolution of your condition, as quickly as possible!

2. **Before we begin treatment, do you have any concerns or questions that you would like us to address about the therapy?**
   This includes manipulation, treatment method, changing into gowns, previous experiences, office polices etc. We believe that good patient communication is essential - we always want to know your perspectives - both positive and negative.

3. **Is there a particular technique that you would like us to use in your case?**
   If it is appropriate, we will endeavour to fulfill your preference.

   - ☐ **I would like the doctor to decide which technique is the most appropriate for treating my condition.**
   - ☐ **Active Release Techniques:** ART is a powerful, focused, and effective technique for finding and releasing soft-tissue restrictions and adhesions. Dr. Abelson is a senior practitioner of this technique, and serves as an Instructor for ART www.activerelease.com.
   - ☐ **Graston Techniques – GT:** An instrument-assisted form of soft tissue mobilization that is used to break down scar tissue and fascial restrictions. The Graston Technique utilizes specially designed stainless steel instruments to release adhesions.
   - ☐ **Modified Diversified:** Manual adjusting and mobilization of joints performed by hand, applying a biomechanical perspective to problem resolution.
   - ☐ **Medical Acupuncture:** Used to assist in treating musculoskeletal conditions.
   - ☐ **Therapeutic Massage:** We have several registered massage therapists on staff.
   - ☐ **Stop Smoking Program:** Smoking slows healing and causes inflammation.
   - ☐ **Weight Loss/Gain Program:** Exercise and dietary approach, long term planning.
   - ☐ **Exercise rehabilitation protocols:** This is a fundamental aspect of all our programs.

Informed Consent to Chiropractic Adjustments and Soft Tissue Therapy

Dr. Brian Abelson DC and Associates

Kinetic Health®
Soft Tissue Management Systems
Bay #10 – 34 Edgedale Dr. N.W.
Calgary, Alberta, T3A-2R4

I hereby request and consent to the performance of Chiropractic Adjustments and other Chiropractic procedures, including but not limited to various modes of manual/physical therapy (Active Release Techniques, Graston Techniques, TCM procedures, Acupuncture, Therapeutic Stretching, Massage, and, if necessary, diagnostic x-rays), upon myself by Dr. Brian Abelson DC or his associates and/or other office or clinic personnel.

I further understand, and am informed that, as in all health care, in the practice of Chiropractic, there are some **very slight risks** to treatment, including, but not limited to the following:

- Rare cases of rib fractures, muscle and ligament sprains or strains following manual adjustments.
- There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment.

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years, and have been demonstrated to be highly effective treatment for back pain, and musculoskeletal pain. As with any healing/medical profession I understand there are no guarantees of cure or guarantees of full resolution of my condition.

I acknowledge that I have discussed, or have had the opportunity to discuss, with either Dr. Abelson, his associates, or staff, the nature and purpose of Chiropractic treatment in general and my treatment in particular, as well as the contents of this Consent Form.

I therefore intend this consent to apply to all my present and future Chiropractic care with Dr. Abelson, and his associates at this or other clinic locations, sporting, or other media events.

Date:

Patient Name and Signature: _____ Witness: _____

Clinic Information

Office Hours

Monday 8 – 5 pm	Tuesday 8-7:00 pm	Wednesday 8 – 5 pm	Thursday 8-7:00 pm	Friday 8 – 5 pm	Saturday 9-2 pm	Sunday Closed

Note: Clinic will be closed all statutory holidays.

Fee Schedule

- For information on specific fees, please phone our clinic at **403-241-3772.**
- Payment is due upon services being rendered. We accept cash, debit card, MasterCard, and Visa.

Extended Insurance

- **Note**: It is the patient's responsibility to confirm extended coverage with their insurance company. Unfortunately, we do *NOT* directly bill secondary insurance companies on your behalf, but we will gladly assist you with your individual insurance forms.

Workers Compensation Board and Motor Vehicle Accident Cases

- Kinetic Health is an authorized provider of WCB and accepts MVA cases. If your claim is to be processed through WCB or MVA insurance, please notify the staff at Kinetic Health in advance or upon your first visit. Kinetic Health will not be held responsible for payments not reimbursed by WCB or MVA. It is ultimately the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Contact Information

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Calgary, AB, T3A-2R4

Phone: 403-241-3772

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Email: kinetichealth@shaw.ca

Web Sites: www.drabelson.com

www.activerelease.ca

www.releaseyourbody.com