Kinetic Health

Soft-Tissue and Sports
Improvement Systems
Bay #10 – 34 Edgedale Drive NW
Calgary, Alberta
T3A-2R4

Phone:
403-241-3772

Fax:
403-241-3846

Email:
kinetichealth@shaw.ca

Websites:
www.kinetichealth.ca
www.activerelease.ca
www.releaseyourbody.com

Patient Admittance Form - Kinetic Health

Date:_____

Name: _____
(Family Name) *(First Name)* *(Initials)*

Contact Information

Home Address: _____

Postal Code: _____ Phone (w): _____

Phone (h): _____ Phone (c): _____

Email Information

_____ _____ _____
Your Email Address *Patient's Initials* *Date*

☐ You agree that by providing this email address, and by initialing this document, that you have read the following *Terms of Usage*, and agree that we can send you email communications to confirm appointments, provide exercise and health instructions, provide health updates, service updates, and send information through clinic newsletters. You can opt-out of this service at any time.

Terms of Usage: 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, health updates and clinical newsletters. Email also provides you with a means of asking your practitioner questions when they are not able to answer phone calls while treating patients. At any time, you can chose to opt-out of our email information services.

Your Details

Sex: ☐ Male ☐ Female Occupation: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Spouse: _____

Health Information

Alberta Health Care #: _____

Family Doctor: _____ Phone: _____

Insurance Information

Insurance Company: _____ Policy Holder's Name: _____

Blue Cross	**All Other Insurance Companies**
ID #:	**Policy #:**
Group #:	**Member ID #:**

I _____ authorize Kinetic Health to submit my claims
(Name of Policy Holder) information electronically, on behalf of myself, or for

_____. _____ _____
Name of Child or Spouse) *(Date)* *(Signature)*

What is your chief complaint (the primary reason you are coming to our clinic?
(Please provide a detailed description)

How did you hear about Kinetic Health?

Emergency Contacts

Who should we contact if there is an emergency?

Name: _____

Phone: _____

Would you like to see a particular Physician?

☐ YES ☐ It does not matter

If YES:

☐ **Dr. Abelson**

☐ **Dr. Mylonas**

Clinic Staff Enters the Following

Blood Pressure: _____

Pulse: _____

Temperature: _____

Height: _____

Weight: _____

Respiration: _____

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 it's frequency of occurrence?

Do you have a history of similar conditions occurring in the past? If YES, please provide details.

Is the condition getting:

- ☐ Worse
- ☐ Same
- ☐ Better
- ☐ Consistent
- ☐ Recurring

How does your condition interfere with 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 (MVA), or have you recently been in an accident?

- ☐ NO
- ☐ YES

If YES please inform our front desk so that we can process your case correctly.

Is this a Worker's Compensation Board (WCB) case?

- ☐ NO
- ☐ YES

If YES please inform our front desk so that we can process your case correctly.

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

- ☐ Persistent
- ☐ Intermittent
- ☐ Aching/Throbbing
- ☐ Tingling
- ☐ Numbness
- ☐ Burning
- ☐ Shooting pain
- ☐ 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 provide details.

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 (provide details)

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
- ☐ Dryness
- ☐ Eczema
- ☐ Fungal Infection
- ☐ Herpetic Infection
- ☐ Itching
- ☐ Lumps
- ☐ Pain
- ☐ Polyps
- ☐ Psoriasis
- ☐ Rashes
- ☐ Scars
- ☐ Shingles
- ☐ Steroid Therapy
- ☐ Swelling

Vision

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

Cardiovascular

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

Ears

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

Head

- ☐ Concentration
- ☐ Concussion
- ☐ Headaches
- ☐ Insomnia
- ☐ Memory Decline

Mouth/Throat

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

Gastro-intestinal

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

Urinary

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

Hair

- ☐ Color Changes
- ☐ Recent Loss

Vascular

- ☐ Anemia
- ☐ Cold Hands and Feet
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Hemorrhoids
- ☐ Leg pain after walking
- ☐ Raynaud's Disease
- ☐ Swelling
- ☐ Thrombophlebitis
- ☐ Varicose Veins

Musculoskeletal

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

Neurological

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

Endocrine

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

Female Reproductive

- ☐ Pregnant
  - ☐ NO
  - ☐ YES: Due-Date_____
- ☐ Birth Control Pills
- ☐ Bleeding Between Periods
- ☐ Discharges
- ☐ Frequent Periods
- ☐ HIV
- ☐ Hysterectomy
- ☐ Increased Flow Duration
- ☐ Increased Menstrual Flow
- ☐ Lumps
- ☐ Menopause
- ☐ Painful Menstrual Cycle
- ☐ Pelvic Inflammation
- ☐ PMS
- ☐ Regular Period
- ☐ STD

Male Reproductive

- ☐ Impotence
- ☐ Prostate Problems
- ☐ Pus Discharge
- ☐ Rashes
- ☐ STD
- ☐ Testicular Pain
- ☐ Trouble with Urination

Pain or Numbness

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

Other Conditions

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

Family History

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

Childhood Conditions

Check all the conditions that you have ever had during your life:

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

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?

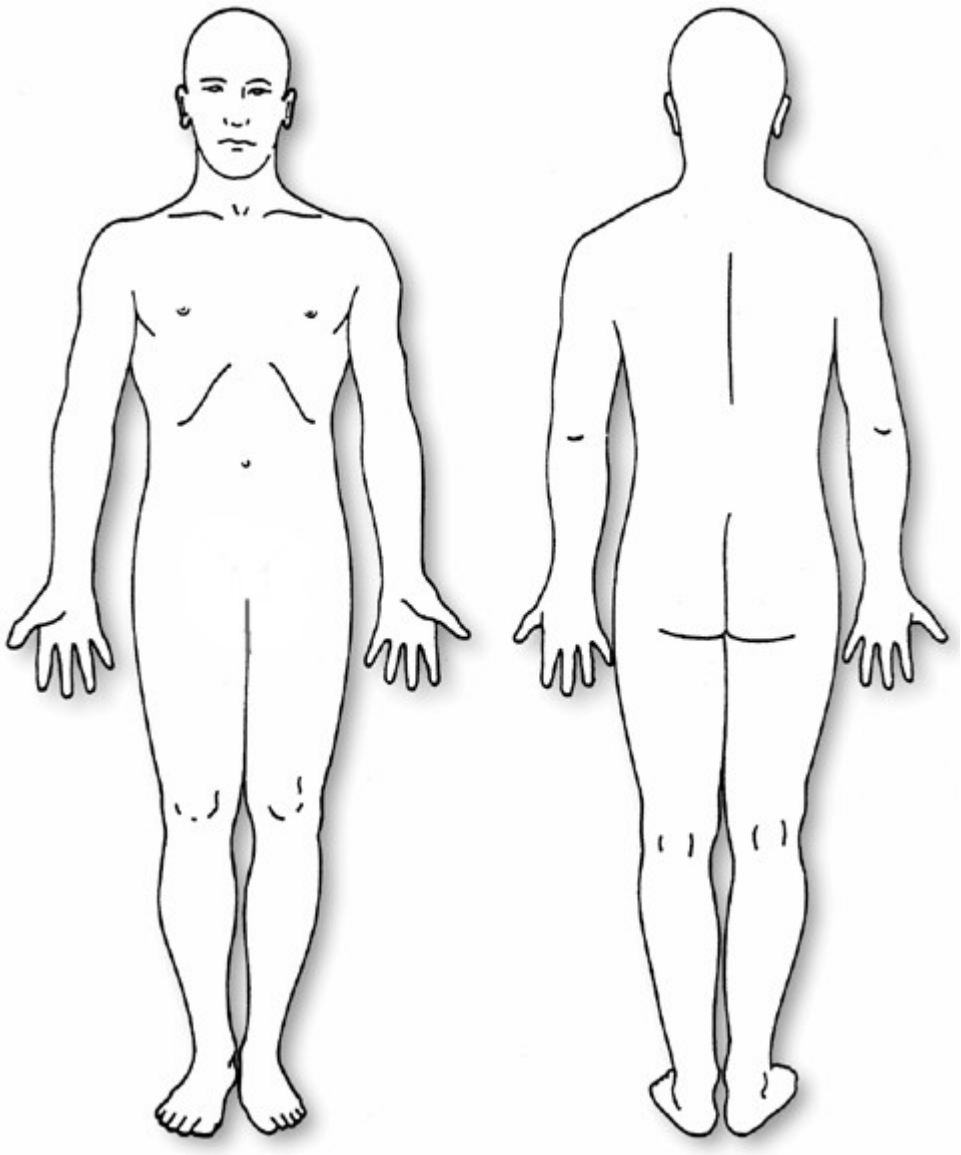
_____

_____

_____

_____

Pain Diagram



Please number the areas in which you are experiencing pain or discomfort.

Use the following pain scale to indicate the intensity of pain in each area of the body.

Pain Scale	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.

More Information

Exercise and Lifestyle

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.

Do you do cardiovascular exercise on a regular basis?

- ☐ NO
- ☐ YES: How many times a week?_____

Do you perform stretching exercises on a regular basis?

- ☐ NO
- ☐ YES: How many times a week?_____

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

- ☐ NO
- ☐ YES
  - ☐ Machines.
  - ☐ Free weights.
  - ☐ Both.

Do you experience chest pain with mild exertion?

- ☐ NO
- ☐ YES

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

- ☐ NO
- ☐ YES

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

- ☐ NO
- ☐ YES

Have you experienced leg pain upon exertion?

- ☐ NO
- ☐ YES

Sleep

Circle hours of sleep per night

2-4 hrs | 4-6 hrs | 6-8 hrs | 8-10 hrs | 12+ hrs

How do you feel when you wake up?

- ☐ Usually wake up feeling refreshed.
- ☐ Usually wake up feeling tired.
- ☐ I am often tired throughout the day.

Smoking:

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

- ☐ NO
- ☐ YES

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 25 pounds.
- ☐ I need to gain weight.

Dietary Habits

How many times do you eat per day?

- ☐ Once.
- ☐ 2 times per day.
- ☐ 3 times per day.
- ☐ 3 times per day plus snacks.

How many times per week do you eat out?

- ☐ Once.
- ☐ 2-3 times per week.
- ☐ 4-5 times per week.

How many glasses of water do you drink per day?

- ☐ 1 to 3.
- ☐ 3 to 5.
- ☐ 6 to 9.

How many cups of coffee do you drink per day?

- ☐ None.
- ☐ 1 to 3 .
- ☐ 4 or 6.
- ☐ More.

Stress

Stress is defined as your individual response to environmental demands or pressures (it could mean just being constantly busy with no down time).

How would you rate your current level of stress?

- ☐ 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 would like you to answer 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 prefer us to use in your treatment?**
   If it is appropriate, we will endeavor to fulfill your preference.

- ☐ **I would like the doctor to decide which technique is the most appropriate for treating my condition.**
- ☐ *Chiropractic Manipulation* –Manual adjusting and mobilization of joints performed by hand, using a biomechanical perspective to resolving your problem.
- ☐ *Active Release Techniques* – ART is a hands-on procedure that is used for finding and releasing soft-tissue adhesions and scar tissues.
- ☐ *Fascial Manipulation* – This soft tissue technique releases restrictions in the fascia that weaves through, and connects all the structures of the body.
- ☐ *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.
- ☐ *Acupuncture* – Used to assist in treating musculoskeletal conditions.
- ☐ *Therapeutic Massage* – We have several excellent and highly skilled Registered Massage Therapists on staff.
- ☐ *Exercise Rehabilitation Protocols* – This is a fundamental aspect of all our programs.

Kinetic Health®

Dr. Brian Abelson D.C. &
Dr. Evangelos Mylonas D.C.
Soft Tissue Management Systems
Bay #10 – 34 Edgedale Dr. N.W.
Calgary, Alberta, T3A-2R4
403-241-3772

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.

Note: We are musculoskeletal practitioners (MSK) and do not directly treat conditions such as cancer, infections, or auto-immune conditions. If you have such conditions, be sure to follow the advice of your medical practitioners.

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

CCPA 09.14

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent for Acupuncture Care FORM - AC

Kinetic Health®
Dr. Brian Abelson D.C.
Soft Tissue Management Systems
Bay #10 – 34 Edgedale Dr. N.W.
Calgary, Alberta, T3A-2R4
403-241-3772

Only sign this Consent if you are receiving Acupuncture Treatments

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above- named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

Date Signed	*Print Patient's Name*	*Signature of Patient (or parent/guardian)*
Date Signed	*Print Witness Name*	*Signature of Witness*

Clinic Information

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9:00 AM to 6:30 PM	8:00 AM to 5:00 PM	8:00 AM to 7:00 PM	8:00 AM to 7:00 PM	8:00 AM to 5:00 PM	10:00 AM to Closing	Closed

Note: Clinic will be closed on all statutory holidays.

Fee Schedule

- For information about specific fees, please phone our clinic at **403-241-3772.**
- Payment is due upon services being rendered. We kindly accept cash, debit card, MasterCard, and Visa.
- In ALL Cases: Patients are responsible for any payments that are not reimbursed by their insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Extended Health Insurance

(We Submit Claims from Most Health Policies)

Both TELUS Health and BlueCross Health Care now offer a secure system that links us directly to your health care insurance, and allows us to submit your treatment claims directly to your insurance company. We, at Kinetic Health, are happy to submit insurance claims on your behalf - immediately after your payment has been processed by Kinetic Health.

All we need from you is some basic information, along with your authorization, so that we can set up the *Direct Claims Submissions* on your behalf. Here is the simple process:

1. Provide your insurance information to Kinetic Health.
2. Sign to authorize and allow Kinetic Health to submit a claim on your behalf.
3. Immediately after your treatment, pay for your treatment at the front desk.
4. We submit your claims information directly to your insurance company via a secure system.
5. Within one to three weeks (in most cases) your insurance company will either mail you a cheque, or deposit the claim amount directly into your bank account (depending on the arrangements you have made with your insurance company).

The amount of reimbursement you receive is dependent on your insurance coverage. Many insurance plans cover a set amount per year for Chiropractic and Massage treatments, while others cover a percentage of treatment (80% to 100% of treatment costs). It is well worth registering for this process, as the claim is quickly processed, and the money is soon back in your pocket!

Motor Vehicle Accident Cases

Kinetic Health accepts MVA cases. Please be sure to notify the staff at Kinetic Health in advance if your claim is to be processed through MVA insurance.

Worker's Compensations Board

Kinetic Health accepts WCB cases. If your claim is to be processed through WCB insurance, please notify the staff at Kinetic Health in advance.

Contact Information

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Web Sites: www.kinetichealth.ca / www.releaseyourbody.com