



1815 10th Ave SW
Calgary, AB T3C 0K2
P: 403-270-7252 F: 403-283-6896
info@nationalspinecare.com
www.nationalspinecare.com

WELCOME TO NATIONAL SPINE CARE AND SPORTS MEDICINE

We look forward to your first visit to our clinic and the opportunity to serve you. We would like to take this time to review some important points prior to your first appointment.

Clinic Location

1815 10th Avenue SW
Calgary, Alberta T3C 0K2
Phone: 403-270-7252 Fax: 403-283-6896
Web: www.nationalspinecare.com

Hours of Operation

Monday: 7:00 a.m. – 8:00 p.m.
Tuesday: 7:00 a.m. – 7:00 p.m.
Wednesday: 7:00 a.m. – 7:00 p.m.
Thursday: 7:00 a.m. – 8:00 p.m.
Friday: 7:00 a.m. – 5:00 p.m.

Parking

National Spine Care has parking stalls in the parking lot on the east side of our building. Our stalls are marked – please look for the signs. Please do NOT park in any stall other than one assigned to National Spine Care as you may be towed. Alternate parking includes free hourly street parking on most of the roads around our location. Parking is clearly marked by City of Calgary signage.

Cancellation Policy

We require 24 hours advance notice for appointments should you need to cancel or reschedule your appointment. There may be a charge for the full amount of your appointment if proper notification is not provided. You may request a reminder call, text or email prior to your scheduled appointment. This is a courtesy and not an obligation of National Spine Care. You are ultimately responsible for keeping the appointment time.

Appropriate Dress

Please wear or bring loose comfortable clothing, such as T-shirt, shorts or sweat/yoga pants.

Registration Package

Please print out the new patient intake forms and fill them out prior to arriving. If you haven't done that, please arrive 15 minutes prior to your scheduled appointment to allow time to complete these forms.

Billing and Insurance Information

Payment is expected at the time of your visit. We accept MasterCard, Visa, debit, cash and cheque.

We direct bill to *Blue Cross, Green Shield, Equitable Life, The Co-Operators, Sun Life, Manulife, Great West Life, and others - please bring your insurance information with you.* Patients are responsible for all services not covered by their health insurance. For any other insurance provider, we are happy to provide documentation of your treatment, which you can file with your insurance company for reimbursement. A visit to one of our medical doctors is covered by the Alberta Health Services, but some of their treatments, mainly various injections, are not covered, which may or may not be covered through extended health benefits.

What to Expect on Your First Visit

Your initial assessment will take between 30 and 45 minutes (depending on which health discipline you see). Please advise us of any relevant imaging (MRI's, X-rays, ultrasounds) taken within the last 2 years so we can obtain the report(s) prior to your appointment. A practitioner will review your medical, health and pain history, imaging reports, and perform a detailed examination. Your diagnosis will be explained to you in detail so that you fully understand the cause of your issue. After your assessment, the practitioner will prescribe a treatment plan designed to meet your specific health goals and needs. Further testing may be recommended to clarify your diagnosis. If it is determined that the treatment we provide cannot help you, a referral to the appropriate specialist will be made. With your consent, we can provide your family doctor with a consultation letter summarizing the findings of your assessment and outlining any recommended treatment plan.

If you have any questions, please call our clinic at 403-270-7252.

We look forward to meeting you!

Coordinated Injury Rehabilitation, Pain Management, and Preventative Medicine

Chiropractic ~ Physiotherapy ~ Sports Medicine ~ Family Medicine ~ Acupuncture ~ Massage



1815 10th Ave SW
Calgary, AB T3C 0K2
P: 403-270-7252 F: 403-283-6896
info@nationalspinecare.com
www.nationalspinecare.com

PATIENT DEMOGRAPHICS

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: Male Female Other

Address: _____

City: _____ Province: _____ Postal Code: _____

Preferred Phone #: _____ Alternate Phone #: _____

E-mail: _____ Alberta Health Care #: _____

Occupation: _____ Typical Working Hours: _____

Dominant Hand: Left Right Height: _____ Weight: _____ Shoe Size: _____

I consent to receive email correspondence from National Spine Care. This may include appointment reminders, newsletters, and other personalized email correspondence.

Emergency Contact First Name: _____ Last Name: _____

Relationship: _____ Phone Number: _____

How did you find us? A nice person named _____ told me about you.

I found you online searching for _____

My family doctor sent me: Yes No

Family Dr. Name: _____ Office #: _____ Fax #: _____

Is this a motor vehicle accident injury? Yes No If yes, date of injury: _____

Is this a work-related (WCB) injury? Yes No If yes, date of injury: _____

Extended Health Insurance: _____

Policy Number: _____

Member/Group Number: _____

I agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also agree that if I suspend or terminate my care or treatment, any fees for professional services will be immediately due and payable. I agree that I am also responsible for any interest charged to outstanding invoices greater than 60 days at an interest rate of 18% per annum

Patient Signature: _____ Date: _____

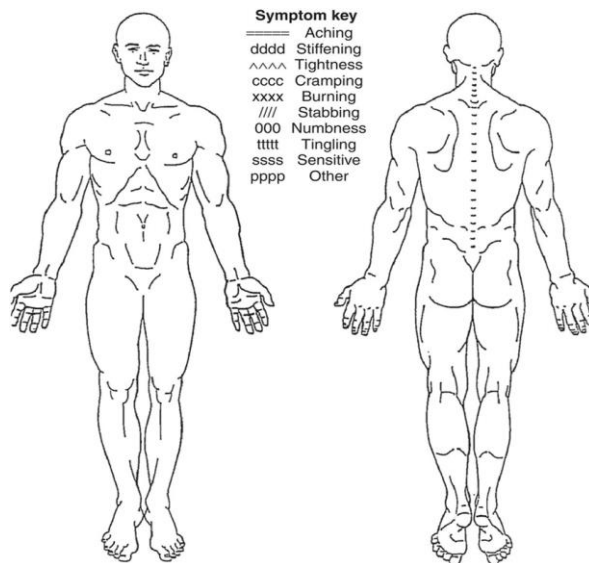
Witness Signature: _____ Date: _____

Coordinated Injury Rehabilitation, Pain Management, and Preventative Medicine

Chiropractic ~ Physiotherapy ~ Sports Medicine ~ Family Medicine ~ Acupuncture ~ Massage

Your story is important. What you feel, how it started, and any patterns you have noticed will help us understand why you have your issues.

Where are you having your issues?



Is this a: New Issue Recurring Issue

When did it start?

How did it start?

What does your pain (health issue) currently limit you doing?

What activities would you love to get back to if we can help you get out of pain?

For you current pain/health issue what treatments have you tried already?

- Physiotherapy Chiropractic
 Massage Acupuncture
 Medications Other _____

Practitioners' Notes Here:

If your issue is one of neck or back pain, please answer the following questions:

Thinking about the **last 2 weeks** tick your response to the following questions:

1. My back pain has **spread down my leg(s)/arm(s)** at some time in the last 2 weeks Disagree (0) Agree (1)

2. I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks Disagree (0) Agree (1)

3. I have only **walked short distances** because of my back pain Disagree (0) Agree (1)

4. In the last 2 weeks, I have **dressed more slowly** than usual because of neck/back pain Disagree (0) Agree (1)

5. It's not really safe for a person with a condition like mine to be physically active Disagree (0) Agree (1)

6. **Worrying thoughts** have been going through my mind a lot of the time Disagree (0) Agree (1)

7. I feel that **my neck/back pain is terrible** and **it's never going to get any better** Disagree (0) Agree (1)

8. In general I have **not enjoyed** all the things I used to enjoy Disagree (0) Agree (1)

9. Overall, how bothersome has your neck/back pain been in the **last 2 weeks**?
 Not at all (0) Slightly (0) Moderately (0) Very much (1) Extremely (1)

Practitioners' Notes Here:

Total score (all 9): _____ Sub Score (Q5-9): _____

Specific Medical History:

Past Surgeries:

Current Medications:

Circle any conditions that are **presently** causing you a problem. **Underline** those that have caused you problems in the **past**.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	CARDIOVASCULAR	GASTROINTESTINAL
Visual disturbance Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hand or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EYES, EARS, NOSE, THROAT	MUSCLE & JOINT	FOR WOMEN ONLY
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders swollen joints Spinal curvature Arthritis Fractures	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other:



1815 10th Ave SW
Calgary, AB T3C 0K2
P: 403-270-7252 F: 403-283-6896
info@nationalspinecare.com
www.nationalspinecare.com

CONSENT TO THE COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

Please note that a photocopy of this consent form will have the same authority as the original. The original form is not to be removed from the client's file at National Spine Care and Sports Medicine (NSCSM).

I, _____, consent to the collection, use and disclosure of my personal information for the purpose of providing services to me as they relate to my injury, illness, treatment and/or my claim for compensation of benefits. In addition, NSCSM may collect, use or disclose my personal information if otherwise permitted or required by law to do so. Personal information includes any information about me other than information that is otherwise publicly available.

NSCSM is a multidisciplinary and collaborative health care clinic with centralized patients' charts. As such, the patient chart information, in its entirety, may be shared among all health practitioners working for the NSCSM.

I understand, and agree, that personal information may also be used or disclosed to obtain payment for the services, determine any entitlement to insurance or other benefits, identify treatment outcomes, and the extent of services in this information may be provided to National Spine Care, and referral sources. National Spine Care may also compile anonymized information, not personal information, to provide aggregate statistic for insurance or government agencies when requested to do so or for quality initiatives and clinical research.

I, _____ hereby authorize (please check all applicable boxes) any authorized representative of NSCSM to:

Send copies (by email, mail, or fax) or give a verbal report of my assessment, treatment plan, interim progress reports, discharge plan, and follow up reports as applicable to the individual(s)/organization(s) named below:

Doctor: _____

Insurance Company/Name of Adjustor: _____

Employer/Name of Contact: _____

Lawyer/Personal Representative: _____

WCB/ Case Manager: _____

Other individual to be named: _____

Contact any of the individuals/organizations names mentioned above for the purpose of collecting information regarding my injury, impairment, disability, functional or vocational needs.

Contact my current or previous employer to discuss the physical demands of my regular employment, the availability of modified or transitional work, and to establish a return to work plan as applicable.

Contact _____ for reimbursement purposes only.

I have read the above authorization and indicate my consent by my signature. The authorization shall be valid for 12 months from this date or until _____ (dd/mm/yyyy).

In addition, I consent to the disclosure of my personal information by National Spine Care and Sports Medicine to a third party with the potential or actual sale, reorganization, consolidation, merger or amalgamation of National spine Care and Sports Medicine. My consent for disclosure of my personal information is in these circumstances valid unless I revoke it on written notice to National Spine Care and Sports Medicine.

Signature of client (or duly authorized representative)

Date (mm/dd/yyyy)

Signature of Witness

Date (mm/dd/yyyy)

Coordinated Injury Rehabilitation, Pain Management, and Preventative Medicine

Chiropractic ~ Physiotherapy ~ Sports Medicine ~ Family Medicine ~ Acupuncture ~ Massage