Dr. Greg Haman, BA, DC
Haman Chiropractic and Orthotics *(Grande Prairie Foot Clinic)*

NAME:	**ALBERTA HEALTH CARE#**
ADDRESS:	TODAY'S DATE:
CITY:	WHO CAN WE THANK FOR REFFERING YOU:
PROVINCE POSTAL CODE	
EMPLOYER'S NAME	FAMILY PHYSICIAN'S NAME
YOUR OCCUPATION	DATE OF BIRTH MONTH / DAY / YEAR
HOME PHONE # WORK PHONE #	CELL PHONE# **PLEASE CIRCLE PROVIDER FOR APPT TEXT REMINDER** BELL TELUS ROGERS FIDO KOODO VIRGIN WIND
MALE / FEMALE	EMAIL ADDRESS:

We have a strict 2 hour CANCELLATION notice, please call, email or text (WITH YOUR NAME INCLUDED IN THE TEXT)

Name of Extended Health Insurance Company: _____

We can direct bill for you if you have coverage with Great West Life/ Sun life / Blue Cross/ Green shield / Desjardins/ Manulife/ Pro Benefits Inc/ Maximum Benefit / Standard Life / Chamber of Commerce / ASEBP or Johnson Insurances/ Sirius and Canwest (You are personally responsible for any amount not covered by your benefits)

Please describe the principle health problems which you came to this office for_____

_____

List any other Doctors seen for these problems: _____

List any diagnosis(s) and or treatment: _____

_____

Have you received Chiropractic treatment previously: Yes_____No_____?

Are you seeking treatment for a Work related injury: Yes_____No_____?

Have you lost any days of work? Yes_____ No____? **Dr. Haman DOES NOT handle WCB claims**

Has a Physician treated you for any health condition in the last year? Yes_____No_____if yes explain____

_____

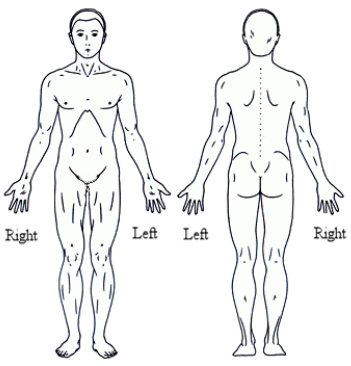
List the approximate dates and any Operations you have had _____

_____

Please X or circle on the figures where you feel pain ➔

Please Circle severity of pain:
0 meaning - No Complaint/Pain and 10 meaning - Worst Possible Complaint/Pain

0 1 2 3 4 5 6 7 8 9 10



If your condition is due to a Motor vehicle accident; please answer the following:

Date_____Time_____AM_____PM_____of Accident

Place or location of accident: _____

MEDICATIONS I NOW TAKE

Nerve Pills
Pain Killers
Muscle Relaxers
Blood Pressure Medicine
Insulin
Other _____

Stimulants
Blood thinners
Aspirin
Tylenol
Cholesterol Medicine
Other_____

HEALTH HABITS

Do you smoke? No Yes _____packs/day
Do you drink alcohol? No Yes _____drinks/week
Do you drink coffee? No Yes _____cups/day
Do you exercise regularly? No Moderate Daily

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have they may seem unrelated to the purpose of the appointment, the care plan and the possibility of being accepted for care.

☐ Severe or Frequent Headaches
☐ Sinus problems
☐ Dizziness
☐ Loss of Sleep
☐ Pain between the painful Shoulders
☐ Frequent Neck Pain
☐ Numbness or Pain in Arms/Legs/Hands
☐ Lower Back Problems
☐ Digestive Problems
☐ Ulcers/Colitis
☐ Heart Attack/Stoke
☐ Depressed
☐ Irritable
☐ Hemorrhoids
☐ Bedwetting

☐ Congenital Heart Defect
☐ Heart Surgery/Pacemaker
☐ Heart Murmur
☐ High/Low Blood Pressure
☐ Difficulty Breathing
☐ Asthma
☐ Arthritis
☐ Alcohol/Drug Abuse
☐ Diabetes
☐ Kidney Problems
☐ Hepatitis
☐ Cancer
☐ Anemia
☐ Thyroid Problems
☐ Trouble Sleeping
☐ Prostate problems
☐ Ear infections

For Women:
Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control? Yes No
Do you experience painful periods? Yes No
Do you have irregular cycles? Yes No

Initial Visit and Exam
Adult……$ 85.00
Seniors/Students/Child….$ 75.00

Regular Office visit (Subsequent Visits)
Adult……50.00
Seniors/Students/Child…….45.00

X-ray
Consult & Reading……..$ 45.00

Footmaxx ® Prescription Orthotics
Exam and Gait analysis only...$ 45.00
Orthotics…… $ 425.00 to $460.00
Shipping…… $ 15.00

Products
Chiroflow Pillow……..$65.00
Biofreeze……..……$18.00

Out of respect for other patients we ask for a minimum 2 hours cancellation notice.
You can call us at 780-882-6888 or email us at hamanchiro.com to cancel your appt.

You will be charged the full fee of your visit if you do not cancel. This cannot be paid by your Insurance Company
_____ **(Please initial).**

EMERGENCY CONTACT:

_____

_____

NAME PHONE NUMBER

YOUR SIGNATURE: _____ DATE: _____

(Patient Parent or Guardian)