Dr. Greg Haman, BA, DC
Haman Chiropractic and Orthotics

NAME:	Alberta Health Card No #
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#**
MALE / FEMALE	EMAIL ADDRESS:

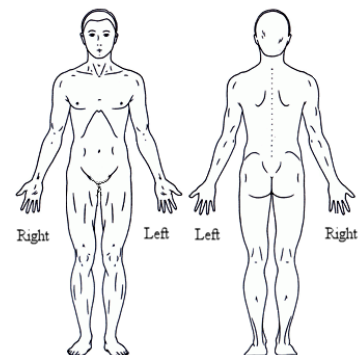
We have a strict 24 hour CANCELLATION notice please call or email to cancel or reschedule an appointment

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
(you are personally responsible for any amount not covered by your benefits)

Main Complaint:
Location:
How did it start?
When did it start?
How often do you feel it (25% of the time, half the day, all day)?
Does it radiate anywhere?
What type of pain is it (Sharp, shooting, dull, achy, tight)?
How bad is the pain (0-10 scale. 0-no pain, l(unbearable)?
What makes it worse or better?
Does It wake you up at night?
Any numbness or tingling?

Please X or circle on the figures where you feel pain ➔
Please Circle severity of pain:
0 meaning - No Complaint/Pain
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 now; or have ha... to the purpose of the appointment, they can affect the overall diagnosis, care ... care.

- □ Severe or Frequent Headaches
- □ Sinus problems
- □ Dizziness
- □ Loss of Sleep
- □ Pain between the Shoulders
- □ Frequent Neck Pain
- □ Numbness or Pain in Arms/Legs/Hands
- □ Lower Back Problems
- □ Digestive Problems
- □ Ulcers/Colitis
- □ Heart Attack/Stroke
- □ 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 & Children……………….…..$ 95.00
Seniors………………..…………...$80.00
Regular Office visit (Subsequent Visits)
Adult & Student/Child …………………65.00
Seniors…………………… ………….50.00
X-ray
Consult & Reading……………..$ 65.00

Footmaxx ® Prescription Orthotics
Exam and Gait analysis only........$ 65.00
Orthotics………….. $ 475.00 to $525.00
Shipping……………………..….. $ 25.00
Products
Chiroflow Pillow………………….$65.00
Biofreeze…………………….……$20.00
Pure Essential………………………$21.00

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 or Parent or Guardian)

Dr Haman DOES NOT handle WCB claims

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.

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