Kinetic Health

At Kinetic Health we employ a variety of techniques to resolve a broad range of soft-tissue and joint-related injuries, including:

- Achilles Tendonitis
- Ankle Injuries
- Back Pain
- Bunions
- Carpal Tunnel Syndrome
- Foot Pain
- Foot Injuries
- Frozen Shoulders
- Gait Imbalances
- Golfer's Elbow
- Golf Injuries
- Hand Injuries
- Headaches
- Hip Pain
- Illiotibial Band Syndrome
- Knee Pain
- Leg Pains
- Muscle Pulls and Strains
- Neck Pain
- Plantar Fasciitis
- Repetitive Strain Injuries
- Rotator Cuff Syndrome
- Running Injuries
- Scar Tissue Formation
- Sciatica
- Shin Splints
- Shoulder Pain
- Sports Injuries
- Swimmers Shoulder
- Tennis Elbow
- TMJ
- Weight Lifting Injuries
- Whiplash
- Wrist Injuries

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

Date:_____

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

Contact Information

Home Address: _____

Postal Code: _____

Phone (h): _____ Phone (w): _____

Phone (c): _____ Email: _____

Note: All Email addresses are strictly confidential and are never given out to other sources. We maintain a no-spam policy. We use emails to confirm appointments, provide you with exercises, health updates, and clinic 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.

Details

Sex: ☐ Male ☐ Female Occupation: _____

Date of Birth: _____ Age: _____

Marital Status:_____ Name of Spouse:_____

Health Information

Alberta Health Care #: _____

Family Doctor: _____

Phone: _____

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**

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

How did you hear about Kinetic Health?

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
- ☐ Low Blood Pressure
- ☐ Noticed heart racing
- ☐ Pounding Sensation
- ☐ Rheumatic
- ☐ Shortness of breath

Hair

- ☐ Color Changes
- ☐ Recent Loss

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

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?

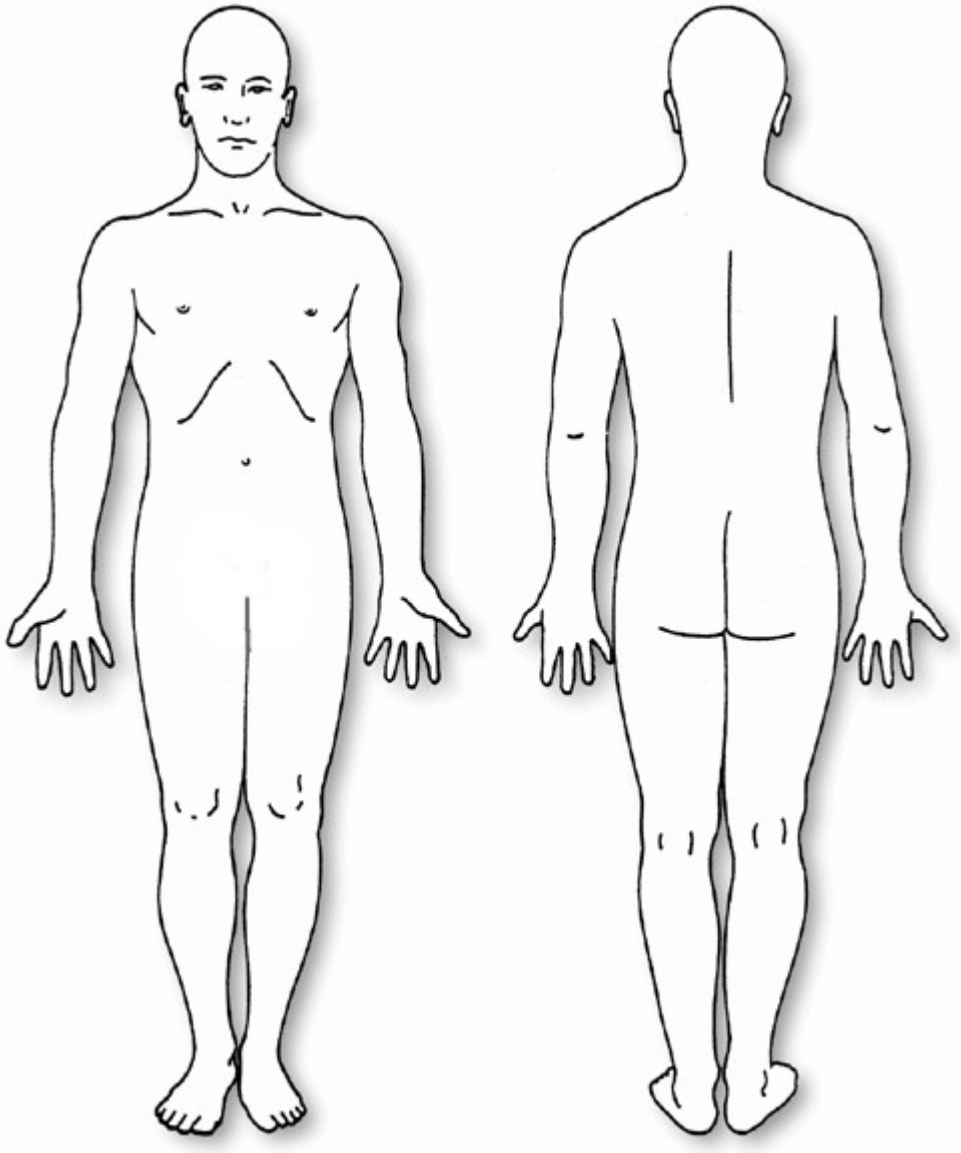
_____

_____

_____

_____

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

- ☐ 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

How would you rate your current level of stress?

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

- ☐ 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.

Informed Consent for Chiropractic Adjustments and Soft Tissue Therapy

Kinetic Health®

Dr. Brian Abelson D.C. and Dr. Evangelos Mylonas D.C.

Soft Tissue Management Systems

Bay #10 – 34 Edgedale Dr. N.W.

Calgary, Alberta, T3A-2R4

403-241-3772

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 **Dr. Evangelos Mylonas DC**, 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, that include, but arenot limited to the following:

1. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

2. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

3. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

4. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

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, Dr. Mylonas, other 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/Spinal adjustments and other treatments with Dr. Abelson, Dr. Mylonas, other Associates, at this or other clinic locations, sporting, or other media events.

Patient Authorization for Treatment

Patient's Name: _____ **Witness Name**: _____

Patient Signature: _____ **Witness Signature**: _____

Patient must be of legal age (18 years) to sign this Consent

Date: _____ **Date**: _____

Parent or Legal Guardian

Legal Guardian Name: _____ **Legal Guardian Signature**: _____

Date: _____

Clinic Information

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 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 2:00 PM	Closed

Note: Clinic will be closed 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, Visa and American Express.

Extended Insurance

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

Motor Vehicle Accident Cases

- Kinetic Health accepts MVA cases. If your claim is to be processed through 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 that are not reimbursed by MVA insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

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, or upon your first visit. Kinetic Health will not be held responsible for payments not reimbursed by WCB insurance. Ultimately, it is the patient's responsibility to pay for all costs incurred at Kinetic Health Clinic.

Contact Information

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