East Central Chiropractic & Rehabilitation Intake Form

Last Name:	First Name:	AHC Number:
Date of Birth: DD / MM / YYYY	Age:	Administrative Gender: M / F
Address:	City, Province:	Postal Code:
Phone (Home) ( )	Phone (Work)( )	Phone (Cell) ( )
Email address:		
Emergency Contact Name:	Emergency Contact Phone( )	

Third Party Insurance Information	
Third Party Insurer Name:	
Policy Holder:	Relationship to Policy Holder:
Group/ Policy #:	ID/ Certificate #:

Please check all answers and fill in the blanks where appropriate.

Is this a work related injury or WCB claim? Yes No Has your employer been notified? Yes No
Is this a Motor Vehicle Accident (MVA)? Yes No On what date did the accident occur? _____

Reason(s) for appointment: _____
When did your condition begin? _____

Have you ever had similar problems? Yes No Have you ever been treated for this problem? Yes No
If yes, please describe what did or did not work for you: _____
Have you had previous chiropractic care? Yes No Dr. _____ Date: _____
If yes, please describe what did or did not work for you: _____

Have you had X-rays, MRI, blood work or other tests for this condition? Yes No Which tests, when? _____

Can you perform daily home activities? Yes Yes, but only with help Not at all
Can you perform your daily work activities? All activities Only some activities Not at all
What is your occupation & regular duties? _____
Describe your stress level None Mild Moderate High
Do you exercise? Yes No What kinds of exercise do you do? _____

Family doctor name: Dr. _____
Do you give consent to allow us to contact your medical doctor/clinic if needed? Yes No
Height: _____ Weight: _____ Blood Pressure: _____

Name: *(please print)*

Please list all previous surgeries, traumas, illnesses, injuries, accidents (including motor vehicle accidents):

_____

_____

Please list all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: _____

_____

_____

Please list all allergies: _____

_____

Personal & Family Medical History

Please circle if you or your immediate family (parents, grandparents, siblings) have had any of the following conditions:

Myself		**Family Member**	
Cancer	Heart Disease	Cancer	Heart Disease
Stroke	Diabetes	Stroke	Diabetes
Hypertension	High Cholesterol	Hypertension	High Cholesterol
Epilepsy	Other: _____	Epilepsy	Other: _____
None of the above		None of the above	

Is there any other relevant information you feel should be discussed? Yes No Please describe:_____

_____

_____

_____

_____

_____

I concede that the above information is complete and correct to the best of my knowledge. I agree to notify my chiropractor at this clinic immediately of any health changes in the future

Date: _____ Patient signature: _____

Name: *(please print)*

Systems Review

Circle any conditions that are **presently** causing you a problem.
Underline thosethat have caused you problems in the **past**.
~~Put an "X"~~ through each of the sections if you have not experienced any of the listed symptoms

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 Allergies	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance Dizziness Fainting/dropping to floor Convulsions Tremors Headache Numbness Neuralgia (nerve pain) Poor/loss coordination Weakness Concussion	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 Bleeding disorder	Poor/Loss appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FORWOMENONLY**
Eye pain Double vision Blurred vision Ringing in ears Deafness/hearing problems Nosebleeds Trouble speaking/swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Jaw pain Low back pain Mid-back pain (between shoulders) Arm/hand pain Shoulder pain Leg pain Knee pain Ankle/foot pain Pain/numbness down arms or legs Swollen joints Spinal curvature Arthritis (osteoarthritis, rheumatoid arthritis, gout) Fractures	Painfulmenstruation Hot flashes Irregularcycle Crampsorbackpain Vaginaldischarge Nippledischarge Lumpsinbreast Menopausalsymptoms Birthcontrolpills Miscarriages Complicationswithpregnancy Pregnant? Y/N Other:
MISCELLANEOUS		
Depression Anxiety Diabetes Infection HepatitisA/B/C HIV/AIDS Rashes/ itches Psychological disorder		

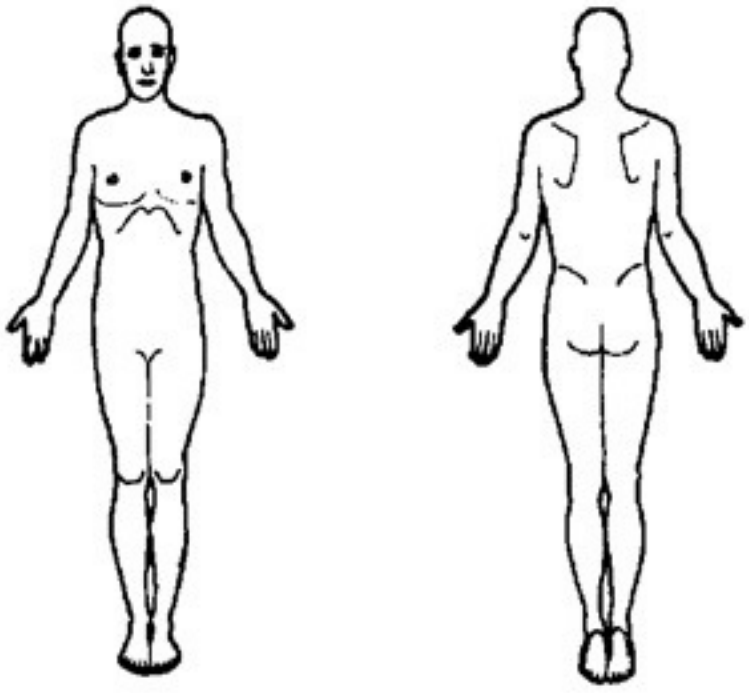
Name: *(please print)*

Health History Questionnaire

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---------- --Yes --No
2. Hardening of the arteries (arteriosclerosis) ---------- --Yes --No
3. Diabetes ---------- --Yes --No
4. Tuberculosis ---------- --Yes --No
5. Cancer ---------- --Yes --No
   Where? _____
6. Heart or blood diseases ---------- --Yes --No
7. Bone spurs on the neck bones (cervical sprain) ---------- --Yes --No
8. Whiplash injury (flexion-extension injury, cervical sprain) ---------- --Yes --No
9. Have you or any of your relatives ever suffered a stroke? ---------- --Yes --No
10. Were you ever a smoker? ---------- --Yes --No
    From _____ to _____
11. Do you take medication on a regular basis? ---------- --Yes --No
12. Visual disturbances (blurring, loss, double vision) ---------- --Yes --No
13. Hearing disturbances (loss, ringing, other noise) ---------- --Yes --No
14. Slurred speech or other speech problems ---------- --Yes --No
15. Difficulty swallowing ---------- --Yes --No
16. Dizziness ---------- --Yes --No
17. Loss of consciousness, even momentary blackouts ---------- --Yes --No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? -------- --Yes --No
19. Sudden collapse without loss of consciousness ---------- --Yes --No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number

| 0 1 2 3 4 5 6 7 8 9 10 |

Nopain Extreme pain

COLLEGE OF CHIROPRACTORS OF ALBERTA

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks, and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment included adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits- Chiropractic treatment has been shown to be effective for complaints of the neck, back, and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relive pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks- The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of the symptoms-** Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn**- Skin irritation or a burn may occur with the use of some typers of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain-** A muscle or ligament sprain or strain may occur. These should resolve withing a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture**- A rib fracture may occur. This can be painful and limit your activity for some time, these usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation-** Some reported cases associate with chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke-** Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech balance and brain function, as well as paralysis or death. If signs of a stroke occur, seek medical attention immediately.

Alternatives- Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest and exercise. Each may have their own benefits and risks.

Questions and concerns- Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (Print)

_____	_____	_____
Patient Signature	Date	Chiropractor Signature

Updated: January 2026

COLLEGE OF CHIROPRACTORS OF ALBERTA

PATIENT INFORMED CONSENT

FOR USE OF ARTIFICIAL INTELLIGENCE (AI) MEDICAL SCRIBE

Purpose of This Consent

East Central Chiropractic & Rehab uses *Freed*, an Artificial Intelligence (AI)–assisted medical scribe, to support the documentation of patient consultations. The purpose of using this technology is to improve accuracy and efficiency in clinical documentation and to allow your healthcare provider to focus more fully on your care during appointments.
Your participation is voluntary. Declining or withdrawing consent will **not** affect the quality of care you receive.

What Is Freed?

Freed is an AI-assisted medical documentation tool that listens to the conversation between you and your healthcare provider and helps generate draft clinical notes for your medical record.

- The information collected may include details about your symptoms, health history, examination findings, and treatment plan.
- Freed **does not** make clinical decisions, diagnoses, or treatment recommendations.
- All clinical decisions are made solely by your healthcare provider.

Privacy, Confidentiality, and Data Protection

East Central Chiropractic & Rehab is committed to protecting your privacy and personal health information.

- Information may be temporarily processed by third-party vendors that support Freed. All vendors are required to comply with the **Health Information Act (HIA)**.
- Data is encrypted and undergoes a **de-identification process** to remove personal identifiers during processing.
- AI-generated notes are **reviewed and approved by your provider** before being added to your electronic medical record (EMR).
- Your information is **not used to train AI models**, is **not sold**, and is **not used for advertising or marketing purposes**.
- Your health information remains part of the clinic's EMR and is protected under the clinic **PIA.**
- Freed does not store patient data long-term. Any short-term data retention complies with **HIA** requirements.

By signing this consent form below, you acknowledge that:

- You have read and understood this form.
- You consent to the use of an AI medical scribe during your visits.
- You understand how your personal information will be used, stored and protected.
- You understand that you can withdraw your consent at any time without impacting the quality of your care. You can withdraw consent by notifying Dr. Larson.

East Central Chiropractic & Rehab Privacy Statement

East Central Chiropractic & Rehab (ECCR) maintains the confidentiality and privacy of individuals' personal and health information while collecting, using and disclosing information in compliance with the *Freedom of Information and Protection of Privacy Act and the Health Information Act*. ECCR supports the right of individuals or their authorized representatives to access and request corrections to their personal and health information, subject to any specific restrictions in applicable legislation.

ECCR will not collect, use or disclose personal or health information in any manner that is not in accordance with the *Freedom of Information and Protection of Privacy Act, the Health Information Act*, or its established policies.

ECCR may disclose personal or health information for approved purposes as authorized by the *Freedom of Information and Protection of Privacy Act or the Health Information Act*.

The ECCR external web site may collect personal or health information when you voluntarily complete any online appointment booking. Personal or health information collected will only be used for the stated purposes. Information is collected pursuant to section 33 of the *Freedom of Information and Protection of Privacy Act* and sections 18–24 of the *Health Information Act*, as applicable.

Patient or Legal Guardian Signature: _____ Date: _____