Name: **Date of Birth:** DD / MMM / YYYY **Visit Date:** DD / MMM / 2021

First Name _____ Last Name _____

Birthdate (dd/mm/yr) _____ Gender _____ Alberta Health Care Number _____

Street Address _____ City _____ Postal Code _____

Preferred Phone Number _____
☐ Home ☐ Mobile ☐ Work ☐ Other

Alternate Phone Number _____
☐ Home ☐ Mobile ☐ Work ☐ Other

Primary Caregiver/Contact _____

Caregiver/Contact Phone Number _____

Family Doctor _____

Last Doctor's Visit (MM/YY) _____

GENERAL HEALTH

Health Priorities/ Chief Concerns:

List your main health concerns in order of importance:

1. _____

   _____

2. _____

   _____

Describe your overall health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

CONSENT PAGE

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as part of providing health care.

In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. Initials: _____

Family Physician: _____

I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission, in accordance with Alberta's *Health Information Act*.

Preferred Method of Communication:

□ Secure (Encrypted) E-mail Initials: _____
Personal E-mail for Use: _____

□ Regular Mail

Collection of Health Information

We are committed to protecting the privacy of your health information and managing your health information in accordance with *Alberta's Health Information Act* (the "HIA"). □ I have read this statement.

We are authorized under Section 20 of the HIA to collect this information. The health information we collect from you is required for the purposes of providing you with diagnostic, treatment and care services. We may also collect your health information:

- to carry out any of the other purposes authorized under the HIA, including, for example, review of the quality of health-care services; and
- if the collection is required by law.

The access and privacy provisions of the HIA require that our clinic protect your personal health information from unauthorized access, collection, use, disclosure or destruction. If you have any questions about how we manage your health information, please contact our Privacy Officer (Adam Henley, RN) at 780-851-9717.

Patient Signature: _____ **Date:** _____

Name: _____ **Date of Birth:** ___ / ___ / ___ **Visit Date:** ___ / ___ / 2021
DD MMM YYYY DD MMM

PHYSICAL ACTIVITY RISK QUESTIONNAIRE

Please read the questions carefully and answer each one honestly. Check YES or NO.

	YES	NO	Details:
Have you been told you have a **heart condition**?	☐	☐	
Do you feel **pain in your chest** during activity?	☐	☐	
In the past month, have you felt **pain in your chest** when not doing physical activity?	☐	☐	
Do you **lose your balance** because of dizziness, or do you ever **lose consciousness** or **faint**?	☐	☐	
Do you have a **bone or joint problem**?	☐	☐	
Is you doctor **currently prescribing medications** for your blood pressure or heart condition?	☐	☐	
Do you know **any other reason** why you should not do physical activity?	☐	☐	

BRIEF LIFESTYLE QUESTIONNAIRE

On a typical week...

How would you describe your diet?
□ excellent □ fair □ poor

How would you describe your sleep?
□ excellent □ fair □ poor

How often do you exercise?
□ almost daily □ at least 3x/week □ occasionally □ rarely □ never

Do you consume coffee, energy drinks or other caffeinated beverages?? □ Yes □ No
If yes, please describe your caffeine intake on a given day?

Do you currently smoke tobacco? □ Yes □ No
If yes, how many cigarettes do you have a day (on average)? _____ cigarettes/day

Do you currently use cannabis? □ Yes □ No
If yes, please describe your cannabis use on a given day?

Do you drink alcohol? □ Yes □ No
If yes, how many drinks do you have <u>each week</u> on average?
□ 0-4 drinks □ 4-10 drinks □ 10+ drinks

Do you use any over-the counter medications or supplements? □ Yes □ No
If yes, please list what OTC medications or supplements you are currently taking.