Buzek CHIROPRACTIC
41 Princess Street, Leamington, ON
519.322.4859 • www.buzekchiropractic.ca

Welcome To Our Office!

To ensure your visit with us is a pleasant one, here are the procedures you can expect during the next 60 minutes.

PAPERWORK Complete this brief questionnaire and health history to help us get to know you. Dr. Buzek will use this information to help formulate the recommendation for your care.
CONSULTATION You will meet with Dr. Buzek and our Chiropractic Health Technician. Dr. Buzek will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.
EXAMINATION & SPINAL SCANS Standard physical, orthopaedic, neurological and chiropractic tests will be performed to determine the cause(s) of your subluxation. Necessary scans may be performed to visualize the location of any spinal problems, neurological interferences and make your chiropractic care precise.
CORRELATION In order to determine the best course of care for your individual case, the Doctor will study your examination findings. You will see the scans, review your findings and receive specific care and recommendations from Dr. Buzek at your next visit.

CONFIDENTIAL GENERAL PATIENT INFORMATION

Patient #: _____
HIP #: _____ Dx: ___

Date: _____ Primary Care Provider: _____

Name: _____ How would you like to be addressed? _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Address: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____ Cell/Other: _____

Email _____

Do you give permission for our office to email information/appointment reminders to this address? □ Yes □ No

Emergency Contact and Phone: _____

Were you referred to our office? □ Yes □ No If yes, by whom? _____

Have you been to a chiropractor before? □ Yes □ No If yes, when were you last adjusted? _____

EXTENDED HEALTH COVERAGE
□ Yes □ No

Primary Insurance Company: _____ Subscriber Name: _____

Patient Relationship to Subscriber: self / spouse / child / other: _____

Policy Number: _____ Id Number: _____

Secondary Insurance Company: _____ Subscriber Name: _____

Patient Relationship to Subscriber: self / spouse / child / other: _____

Policy Number: _____ Id Number: _____

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1. I understand that I am responsible for charges not covered or reimbursed by my extended health plan or similar payer. I agree to pay BCC directly if my benefits plan does not reimburse the provider.
2. I authorize my insurer to release information to BCC regarding my coverage.
3. My right to payment for care, treatments, supplies and other services rendered are hereby assigned to Buzek Chiropractic Clinic. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service rendered. If my insurer does not accept assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payments to Buzek Chiropractic Clinic.
4. I understand and authorize release of all health information about me to my insurer to obtain payment for care, treatment, supplies or other services rendered. The above information is true to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

Thank you. We look forward to a healthy relationship with you!

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Pediatric Information Form (Birth-12 Years)

Patient Information:

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: □ Male □ Female
Parent(s) Name: _____

What is the primary reason that you are seeking Chiropractic care for your child?

_____
When did this problem begin? _____
Is it getting worse? □ Yes □ No
Is this problem: (circle) occasional frequent constant intermittent
Does problem radiate? □ Yes □ No If Yes, where? _____

_____
What makes this worse? _____
What makes this better? _____
Is the problem worse during a certain time of the day? □ Yes □ No
If Yes, when? _____
Does this interfere with the child's sleep?____ eating?____ daily routine?____

Prenatal History:

Any complications during pregnancy:

_____
During pregnancy, did the mother:
Drink alcohol: □ Yes □ No Use tobacco: □ Yes □ No Vaccines/medications □ Yes □ No
Reasons for vaccines/medications: _____
Illnesses/infections during pregnancy: _____

_____
Supplements during pregnancy: _____

_____
Ultrasounds or other testing: _____

_____

Birth History:

Place of birth: □ Home □ Birthing Center □ Hospital
Provider: □ Midwife □ OB-Gyn □ Other
Type of Birth: □ Vaginal □ Cesarean
Duration of gestation: _____ Weeks
Were pain medications used? _____
Was labour induced? _____
Birth trauma? □ Doctor Assisted □ Twisting/Pulling □ Vacuum Extraction □ Forceps
APGAR score if known? _____
Did your child have a misshaped skull/head? □ Yes □ No
Did your child have any bruising in the skull/face? □ Yes □ No Where? _____

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Growth and Development

Was your infant alert and responsive within twelve hours of delivery? □ Yes □ No
At what age did your child:

Respond to sound: _____ Follow an object: _____
Hold up head: _____ Voalize: _____
Begin to teethe: _____ Sit up unassisted:_____
Crawl: _____ Walk: _____

Chemical Stressors

Did you breast feed your child? □ Yes □ No How long? _____
Was formula introduced? □ Yes □ No At what age? _____
Began solids at what age? _____ Type of first food? _____
List any food allergies? _____
Has your child been vaccinated? □ Yes □ No
Did your child have any reactions to these vaccines? □ Yes □ No
Has your child been on antibiotics? □ Yes □ No
If yes, how often and for what purpose? _____
Is your child currently taking any vitamins? □ Yes □ No
If yes, please list: _____
How many glasses does your child drink per day? Water _____ Milk_____Juice _____ Soda_____
Does your child consume artificial sweeteners? □ Yes □ No
Rate your child's diet: □ Well-balanced □ Average □ High sugar/processed food
What is your child's favourite food? _____

Health History: Please fill out if age 0-4 years

Have any of the following occurred?

Jaundice	Colic	Reflux
Anemia	Frequent diarrhea	Fall from a changing table
Cyanosis	Constipation	Fall out of crib
Seizures	Sleeping problems	Fall off playground
Infections	Frequent fevers	Tumble down stairs
Tonsilitis	Frequent crying spells	Play in jolly jumper
Frequent ear infections	Repeated colds	Car accident

Other _____

Health History: Please fill out if age 5-12 years

Have any of the following occurred?

Fall from a tree	Stomach pains	Bed-wetting
Fall off a bicycle	Hyperactivity/Autism	Asthma
Fall on playground	Leg/Knee pains	Allergies
Sports accident	Scoliosis	Growing pains
Car accident	Learning difficulties	Headaches/migraines

Other _____

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Does your child participate in any athletic or extracurricular activities? □ Yes □ No
If yes, which ones? _____
How many hours of sleep does your child get per day? _____
Sleep quality: □ Good □ Fair □ Poor

Is there anything else the Doctor should know? _____
_____

Have you, the child's legal guardian, had any personal experience with Chiropractic? □ Yes □ No
_____

Authorization to Evaluate and Care for a Minor

I, _____, the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request, and direct the staff and doctors of Buzek Chiropractic Clinic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's Name: _____

Parent/Guardian's Signature: _____ Date: _____