Confidential Patient Medical History

Last Name: _____Mr. __Mrs. __ Miss. __Ms. Age: ____ Sex: M F

First Name: _____Height:_____Weight: _____

Email Address:_____Date of Birth:_____

Would you like to receive monthly HEALTH NEWS YOU CAN USE articles by Dr. Rob and/or special promotions via email? Yes/No

Home Address: _____City: _____Postal Code: _____

Home Phone: _____Cell: _____ Work: _____

Occupation:_____Employer: _____

Marital Status: (Circle One) Single Married Divorced Separated Common Law Widowed

Current Complaints:

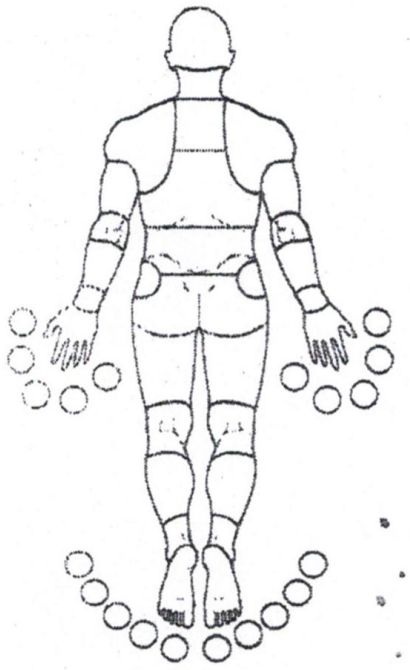
Rate the severity of your pain today:

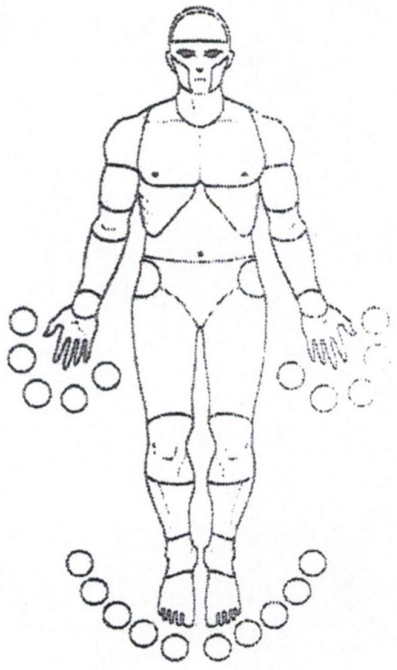
0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Unbearable Pain

Please indicate the current complaints you are experiencing by marking the areas on the image below.

1. headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin





How long have you had this condition?_____ .Have you received care from another health professional? _____ .If Yes, When? _____ Where? _____

Results _____

Have you had any diagnostic imaging, i.e.: x-rays, ultrasound, MRI, CT scans etc.?_____ If yes, When?_____ _____Where? _____ Do you have a copy of the reports? ___

Have you recently had or are currently having:

___Headaches ___Loss of Consciousness ___Walking difficulties (in coordination)

___Visual Problems ___Blood Clots ___Nausea

___Speech Difficulties ___Difficulty swallowing ___Numbness (one side of face or body)

___Fainting ___Tremors? Explain_____

Did this injury occur at work? __Yes __No. If Yes, Date of incident:_____

If yes, has a report been filed with WSIB? __Yes __No. If yes, Case # _____

Is this an injury due to a Motor Vehicle Accident? __Yes __No If yes, Date of Accident: _____

ADDITIONAL INFORMATION IS REQUIRED IF THIS CLAIM IS GOING TO BE BILLED THORUGH YOUR MOTOR VEHICLE INSURANCE. PLEASE ASK FRONT DESK STAFF FOR DETAILS.

Present illness/Condition:

__AIDS
__Allergies
__Anemia
__Arthritis
__Asthma
__Bone Fracture
__Cancer
__Cirrhosis/Hepatitis
__Diabetes
__Dislocated Joints
__Diverticulitis
__Hay Fever
__Heart Problem
__High Blood Pressure
__HIV/ARC
__Kidney Trouble
__Low Blood Pressure
__Mental/Emotional Difficulty
__Multiple Sclerosis
__Pacemaker
__Prostate Problem
__Rheumatic Fever
__Scoliosis
__Sinus Trouble
__Spinal Disc Disease
__Thyroid Trouble
__Tuberculosis
__Ulcer
__Polio
__STD'S
__Epilepsy
__
__
__
__
__

Family History of illness:

__AIDS
__Allergies
__Anemia
__Arthritis
__Asthma
__Cancer
__Bone Fracture
__Cirrhosis/Hepatitis
__Diabetes
__Dislocated Joints
__Multiple Sclerosis
__Heart Problem
__HIV/ARC
__High Blood Pressure
__Kidney Trouble
__Spinal Disc Disease
__Low Blood Pressure
__Mental/Emotional Difficulty
__Prostate Trouble
__Rheumatic Fever
__STD'S
__Sinus Trouble
__Epilepsy
__Thyroid Trouble
__Tuberculosis
__Ulcer
__Polio
__Scoliosis
__Diverticulitis
__

Type of Cancer: __Breast __Lung __Other
Other: _____

Medical Care Information:

Do you have a Family Doctor? __Yes __No Name of Doctor: _____
Location: _____City: _____
Date of last visit: / / Date of last exam: / /
Do you have a Family Chiropractor? __Yes __No Name of Chiropractor: _____
Location: _____City: _____
Date of last visit: / / Date of last exam: / /
Have you had surgeries in the last 5 years? __Yes __No
If yes, last surgery date: / /
Reason for surgery:_____

_____

List previous broken bones or strains: _____

Social History:

Alcohol? __Yes __No Caffeine?___Yes___No Cigarettes___Yes___No Exercise?___Yes___No
Drinks per week___ Drinks per day?___ Packs per day?___ Hours per week?___
Light/Moderate/Strenuous

Misc.:_____
How did you hear about our office?___ Family ___ Friend ___ Co-Worker ___ Signs on Building ___ Internet ___ Other. Please let us know the name of the person who referred you so we can thank them for the referral. _____

Extended Health Information:

If you have Extended Health Insurance, please complete the following and present your insurance cards so we may take a copy for your file for accuracy when billing.

Primary Coverage

Insurance Company Name:_____Employer Name: _____
Plan Member Name: _____Plan Member Date of Birth: _____
Policy/Contract #_____Member ID # _____
Does this plan cover Custom Foot Orthotics? __Yes __No

Secondary Coverage

Insurance Company Name:_____Employer Name: _____
Plan Member Name: _____Plan Member Date of Birth: _____
Policy/Contract #_____Member ID # _____
Does this plan cover Custom Foot Orthotics? __Yes __No

AS A COURTESY TO OUR PATIENTS, WE PROVIDE ELECTRONIC BILLING IF THE PLAN ALLOWS DIRECT BILLING TO THE PROVIDER.

I certify that I am being treated for Chiropractic Care by Dr. Robert Neposlan, DC and herby authorize payments to be processed electronically and paid directly to the provider named above.

_____ _____
Patient/Guardian Signature Date signed

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various techniques whose knowledge and proficiency has been obtained through post-graduate training seminars, on me by the doctor of chiropractic named below. I understand that any procedures or techniques used will be done so for the sole purpose of addressing the condition for which I have presented.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinical personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read the above consent. I have also had an opportunity to ask questions about its content. By signing below, I agree to the above mentioned chiropractic procedures. I intend for this consent form to cover the entire course of treatment for my present condition and any future conditions…

I, the undersigned, have read and understand the above questions/information and have completed them to the best of my knowledge, as completely and fully as possible.

_____ _____
Patient Name (Please Print) Signature of Patient/Guardian Date

_____ _____ _____
Witness Name (Please Print) Signature Date

_____ _____
Dr. Robert Neposlan Date

FINANCIAL POLICY

INITIAL VISIT (Includes Consultation, Examination, Chiropractic Adjustment) **$83.00**
INITIAL VISIT INCLUDING DECOMPRESSION **$93.00**
CHIROPRACTIC ADJUSTMENT **$44.00**
CHIROPRACTIC ADJUSTMENT + ONE ADDITIONAL THERAPY* **$49.00**
CHIROPRACTIC ADJUSTMENT + TWO ADDITIONAL THERAPIES* **$54.00**
CHIROPRACTIC ADJUSTMENT + THREE ADDITIONAL THERAPIES* **$59.00**
DECOMPRESSION (Includes Chiropractic adjustment when needed)**..... $68.00**
RE-ACTIVATION VISIT AFTER 6 MONTHS * $83.00
(May involve Consultation, Examination, Chiropractic Adjustment)

***We are mandated by the Ontario Chiropractic Association to gather a complete Medical History upon Re-Activation**

MISSED APPOINTMENT FEE.....$33.00 ***Patient Initials*** **_____**
*****MISSED APPOINTMENT FEES WILL BE AUTOMATICALLY POSTED TO YOUR ACCOUNT IF A CALL TO OUR OFFICE HAS NOT BEEN RECEIVED PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.
CONSULTATION **$53.00**
***Additional therapies may include: Wave Vibration, Laser, and Pulse Magnetic Therapy**

WELLNESS/MAINTENANCE PLAN:

- If you would like to take advantage of our **Wellness Plan**, you may pre-pay for **12** Chiropractic visits at a discounted rate of 10% per visit with the consideration that services are rendered at a minimum of 1 visit per 4 weeks. This option is also available for other services.

CONSIDERATIONS

I have read and fully understand my financial obligation to the Family Chiropractic Wellness Centre. I also understand that regardless of insurance coverage, I am ultimately responsible for payment of all fees incurred by me at the Family Chiropractic Wellness Centre. If for whatever reason, the F.C.W.C. is not able to collect their fee from the insurance company in a reasonable period of time (90 days or less), I agree to take full responsibility for all charges due and pay them promptly.
Patient Initial **_____**

IMPORTANT NOTICE: A COURTESY CALL TO OUR OFFICE WOULD BE GREATLY APPRECIATED AT LEAST 12 HOURS IN ADVANCE IF YOU ARE UNABLE TO MAKE YOUR APPOINTMENT TIME.

AS A COURTESY TO OUR PATIENTS, WE PROVIDE ELECTRONIC BILLING IF THE PLAN ALLOWS DIRECT BILLING TO THE PROVIDER.