IMPULSE
HEALTH AND WELLNESS

#101- 15399 102A Avenue
Surrey, B.C. , V3R 7K1
604-951-8959

Dr. Leong Wong
Dr. Joe Janek
Dr. Christopher Leong
Dr. Will Mitchell
Dr. Jin Ho Kim

Patient Information: **Nickname/Preferred Name :** _____

First Name: _____ **Middle Initial**: _____ **Last Name**: _____

Street Address:_____ **City**:_____ **Prov**:_____ **Postal Code**:_____

Home:_____ **Cell**:_____ **Work**:_____ **EXT**:_____

Email:_____

Personal Health Number:_____ **Birthdate**: (m/d/yr) _____**Age**: _____ **Height**: _____**Weight**: _____

My Occupation:_____ **Employer**:_____

Gender: □ Male □ Female **Marital Status**: □ Single □ Married □ Seperated □ Divorced □ Common Law □ Widowed

Emergency Contact Name and Number:_____

Name of Spouse/Significant Other:_____

Family Doctor and Number :_____

Previous Chiropractic Care

Have you ever been treated by another Chiropractor? □ Yes □ No

If yes, Chiropractors Name:_____

Reason for seeing previous Chiropractor:_____

Were X-rays taken? □ Yes □ No

When was your last spinal X-rays taken? _____

Did your family receive chiropractic care?

□ Yes □ No

Who can we thank for this referral?

□ Patient from this office (name)

_____

□ Other Health Care Professional (name)

_____

□ Walk By/Sign
□ Website
□ Google
□ Other (specify) _____

What is the purpose of this appointment? Describe in detail: _____

_____

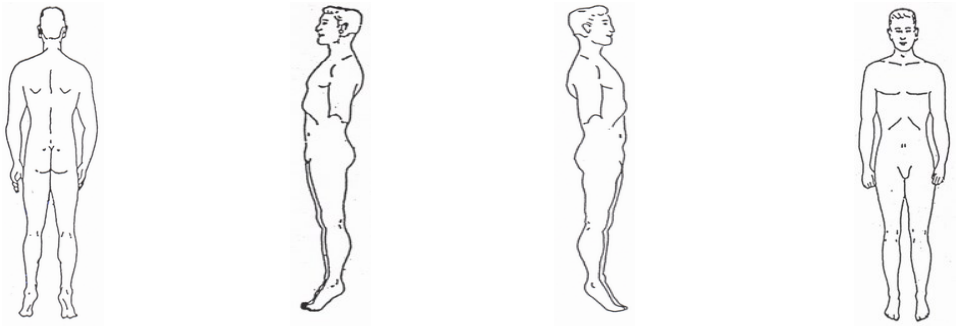
_____

_____

_____

*Patient Name:*_____

Please indicate (circle) on the diagram below the area (s) in which you are experiencing problems.



How long have you had this condition? _____ Have you had this or similar conditions in the past? (When?)_____

How did this happen? _____

With 10 being the worst pain, rate your condition by **circling the number**.

0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Have you ever had an X-ray, CT Scan, MRI, Bone Scan? □ Yes □ No (If yes, Where?) _____ (When?) _____

What were the results? _____

List all previous treatments for this condition: _____

List any other health or medical conditions: _____

Women: Are you pregnant □ Yes □ No If yes, expected due date: _____

List any medications: _____

With 10 being the Best, rate your **Quality of sleep**:

Poor **1 2 3 4 5 6 7 8 9 10 Excellent**

With 10 being the Best, rate your **Diet**:

Poor **1 2 3 4 5 6 7 8 9 10 Excellent**

With 10 being the Best, rate your **Exercise Habit:**

Poor **1 2 3 4 5 6 7 8 9 10 Excellent**

Auto Accidents or Work Injury

Is your visit related to a motor vehicle accident (ICBC) or a work related injury (WorkSafe BC) ?

□ Yes □ No If yes, please inform reception.

Date of accident or injury: _____

Claim Number: _____

Fee Schedule:

Initial Consultation Fee: $125.00

Subsequent Visit Fee: $75.00

X-ray Fee: $37.50 per view

Nervous System Scan: $75.00

FOB or ID Card: $5.00 (Refundable with un-damaged devices)

I, the undersigned, understand that services rendered in this office are responsibility of myself should Medical Services Plan or other third party plans fail to pay all or part of the amount due. I understand 24 hours notice is requested for cancellation of an appointment. I, the undersigned, also understand that each Practitioner is an independent and separate practice operating under Impulse Health And Wellness. I hereby authorize and give consent to the doctors in this clinic to examine my condition and render care as deemed necessary. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

Patient's Signature_____ **Date** _____

(or signature of guardian or spouse authorizing care)

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

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 includes 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 relieve 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 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 types 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 within 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 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 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 or 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 or 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/Guardian Signature Date Chiropractor Signature