Fees, Clinic Hours, & Office Policies

Sydney Chiropractic

Investment For The Treatment

Fee For 1st Visit..... $75.00

Fee For Regular Visit $50.00

Fee For Laser $50.00

Office Hours

Monday: 8:00 – 5:00 pm

Tuesday: 12:00 – 6:00 pm

Wednesday: 8:00 – 5:00 pm

Thursday: 12:00 – 7:00 pm

Friday: 8:00 – 3:00 pm

In order for us to serve you to the best of our ability, we request the following:

1. Payment is due when service is rendered. Booking multiple appointments will save you time at each office visit. We accept Cash, Debit, Visa, and MasterCard.
2. All patients are responsible for payments of their account. If you have extended healthcare, or other insurance covering costs, we will direct bill your health insurance when we are able to do so.
3. If you are unable to keep an appointment, please notify us 24 hours in advance, so we may reschedule your visit, and avoid a missed appointment fee.
4. *All clients are asked to report any new concerns or injuries PRIOR to your appointment. We will determine if your appointment will need to be rescheduled to an Assessment Time for proper evaluation.*
5. Help us keep the air we share healthy and fragrance free. The chemicals used in scented products can make some people sick, especially those with fragrance sensitivities, asthma, allergies and other medical conditions. Please do not wear perfume, cologne, aftershave and other fragrances. Please use unscented personal care products.

It is our intention to serve every patient in our office with the highest quality chiropractic care. Our focus is to deliver the care you need for health and wellness. In order for us to serve you to the best of our ability we welcome any feedback that will make your visit here a great experience. Thank you for allowing us to serve you!

Sydney Chiropractic

Patient Privacy Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting personal information. We are committed to collecting, using and disclosing your information responsibly. We also try to be open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law

Information Disclosure

Your personal information shall be disclosed to only those who have a need to know and the specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include other chiropractors and health care providers. Further, the personal information disclosed to benefit providers is limited to only that personal information required by the provider. You may at any time designate any restrictions as to whom we may disclose your personal information or restrict the content of a disclosure. Your information may be accessed by regulatory authorities under terms of the Chiropractic Act of Nova Scotia and for the defense of a legal issue. **Our office will not under any conditions supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward your information directly to you for your review, and for your specific consent. When unusual requests are received, we will contact you for your permission to release such information. We may also advise you if such a release is inappropriate.**

Your Access to your Records

We are committed to providing you with open access to your personal information held by us. You may at any time ask to view your records and request amendments to that information. We will provide access to you within a reasonable timeframe recognizing your desire for the information and our need to carry on our practice with limited interruption. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Contact or Complaint Process

Should you have any questions, comments, concerns, or complaints regarding our privacy practices, please do so in writing to our privacy officer.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code and I can ask to see the code at any time. I agree that Sydney Chiropractic can collect, use and disclose my personal information about the mentioned person below as set out above in the information about the office's privacy policies.

Signature	Print Name	Date

SYDNEY CHIROPRACTIC DR. DAVID DUNN

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Birthdate: _____ Age: _____

Cell Phone: _____ Gender: Birth: _____ Current: _____ Pronouns: _____

Height: _____ Weight: _____ Business Employer: _____ Business Phone: _____

Type of Work You Do: _____ E-mail: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Who may we thank for referring you to this office? _____

Would you like to receive our monthly e-mail newsletter: ☐No ☐Yes

How did you hear about our office ☐TV ☐Radio ☐Internet ☐Flyers ☐Newspaper
☐Family/Friend ☐Facebook ☐Google ☐Other

CURRENT HEALTH CONDITION

Current Complaint(s): _____

When did this condition begin?: _____ Has it occurred before : ☐Yes ☐No

If this condition has occurred before, when?: _____

What caused it? ☐Work Injury ☐Car Accident ☐Home Injury ☐Fall ☐I don't know

If you know, describe what caused it: _____

If there was an accident or work injury, please give the date: _____

Have you seen other doctors for this condition? ☐No ☐Yes Dr. _____

Type of Treatment? _____ Result of treatment _____

What aggravates your condition? ☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking
☐Lying Down ☐Cold ☐Exercise ☐Other _____

What relieves your condition? ☐Bed Rest ☐Ice ☐Heat ☐Massage ☐Medication
☐Chiropractic ☐Exercise ☐Other _____

Is the problem: ☐Constant ☐Comes/Goes ☐Getting worse ☐Getting better

How does it feel? ☐Sharp ☐Dull ☐Ache ☐Pins and Needles ☐Numb ☐Burning

Other description on how it feels: _____

_____

_____

_____

_____

_____

Place an X on the grade to indicate the **severity** of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? _____

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or sports? _____

At its worst, how **old** does this problem make you feel? _____

If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

Drugs you are now taking: ☐ Painkillers ☐ Muscle Relaxers ☐ Arthritis ☐ Blood Pressure
☐ Insulin ☐ Anit-depressants ☐ Cholesterol ☐ Blood Thinners
☐ Heart Pills ☐ Osteoporosis ☐ Light Sensitive ☐ Other: _____

Do you suffer from any other conditions than the one you are now consulting us for? _____

_____

Have you had X-rays, CT scans, or an MRI of your problem area taken before? ☐ Yes ☐ No

If yes, what test and of what area? _____ When? _____

PAST HEALTH HISTORY

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: _____

Previous: ☐ Childhood Traumas? _____ ☐ Sports Injuries? _____

Hospitalization? (other than above): _____

Previous Chiropractic Care? ☐ No ☐ Yes, Doctor's Name: _____

Approximate Date of Last Visit: _____

FAMILY HEALTH HISTORY

Name and address of Family Physician: _____

_____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____

Have your children ever had a spinal check-up? ☐ No ☐ Yes, where and when? _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the <u>past six months</u>:

Nervous System

- ☐ Nervous
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting
- ☐ Falling
- ☐ Balance Disturbances
- ☐ Convulsions
- ☐ Tingling In Hands/Fingers
- ☐ Tingling In Feet/Toes
- ☐ Numbness/Tingling Elsewhere

Musculo-Skeletal

- ☐ General Stiffness
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulders
- ☐ Headaches
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot/Feet Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing
- ☐ Wrist Pain

General

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss Of Sleep
- ☐ Fever
- ☐ Significant Stress
- ☐ Weight Trouble

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Colitis
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool

Male / Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate Problems
- ☐ Sexual Dysfunction
- ☐ Pregnancy/Birth

Genito-Urinary

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

Females Only
When was your last period?

_____

Are you pregnant?

___Yes ___No ___Not Sure

Dietary Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

- ☐ No
- ☐ Yes, What? _____

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Low

Do you take any vitamins or supplements?

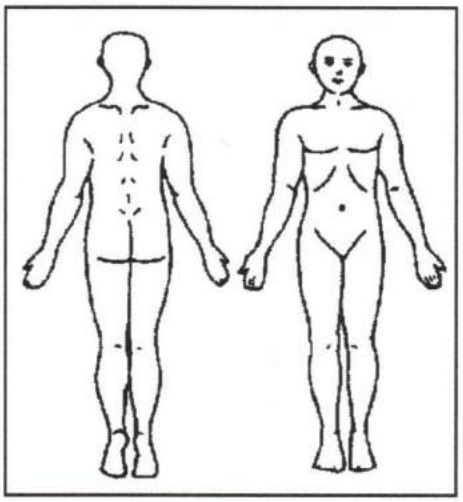
- ☐ No
- ☐ Yes

If yes, please list: _____

_____

_____

_____



Please outline on the diagram the area of your discomfort and any radiation of pain

Check any of the following diseases you have had:

- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Pneumonia
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lupus
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Aortic Aneurysm
- ☐ Cancer
  Past / Present

If Yes, what type and when

_____

_____

_____

_____

"Helping Cape Bretoners live healthier lives since 1978".

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding 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.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor