WELCOME TO
WESTSIDE FAMILY CHIROPRACTIC

live well adjusted

Please relax, breathe and smile. We are happy to have you here!

PERSONAL INFORMATION

Name: _____ ☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr.
Last First Initial

Prefer to be called:_____ How did you hear about us?_____

Is this in relation to: A workplace injury? □ Yes □ No | A motor vehicle accident? □ Yes □ No

Alberta Healthcare #: _____ Email Address : _____

Primary Ph:(___)_____(home/cell) Secondary Ph:(___)_____ (home/cell)

Address: _____

City: _____ Province: _____ Postal Code: _____

Birth Date: Day / Month / Year Age: _____ Sex: ☐M ☐F Height: _____ Weight: _____

Please check one: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Common Law

Occupation:_____ Number of children: _____

Who can we contact in case of an emergency? Name/number: _____

WHY THIS FORM IS IMPORTANT

In our Clinic, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to this office and second, to offer you the opportunity of improved health and wellness in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

CURRENT HEALTH INFORMATION

Why are you consulting our office?

_____

_____

Do you want better health for yourself on a long-term or temporary basis?
□ Long-term □ Temporary

What is your level of commitment to yourself, your life and your well-being?
□ Very committed □ Somewhat committed □ Not committed
Are you healthier now than you were 5 years ago? ☐Yes ☐No
In 5 years do you want to be healthier than you are right now? ☐Yes ☐No

LIFESTYLE INFORMATION

☐Yes ☐No Are you frequently ill?
☐Yes ☐No Do you often feel exhausted?
☐Yes ☐No Do you have trouble sleeping?
☐Yes ☐No Are you pregnant or trying to get pregnant?
☐Yes ☐No Have you ever been told you have cancer?
☐Yes ☐No Do you currently smoke? If yes, packs/day:_____
☐Yes ☐No Do you drink alcohol? If yes, drinks/week: _____
☐Yes ☐No Do you drink coffee? If yes, cups/day:_____
☐Yes ☐No Do you drink pop? If yes, cans/week:_____

Are you currently on a program of: (check all that apply)
□ vitamins □ minerals □ herbs □ diet □ exercise □ others?

_____

How long has it been since you felt really good? □days □weeks □months □years □too long

On a scale of 1-10 describe your stress level: (0=no stress 10=high stress)

- Occupational stress:____/10
- Personal stress:____/10

What is your estimation of your present general health? □poor □fair □good □excellent

Please list any previous or present illnesses or surgeries:_____

_____

BODY STRESS EVALUATION

Lifestyle stress occurs in three dimensions - physical, bio-chemical, and psychological. When you experience these stresses beyond the body's ability to cope and adapt, it has an impact on the nervous system by causing subluxation (misaligned vertebra).

Please check (√) all stresses that you have experienced, **no matter how long ago, mild, or few your exposure may have been.**

1. BIO-CHEMICAL STRESS:

□ Environmental pollution (air, water, etc.)
□ Chemical exposure (solvents, fumes)
□ Smoker
□ Second-hand smoke
□ Poor diet
□ Caffeine (e.g. coffee, pop)
□ Excessive sugar
□ Alcohol/Drugs
□ Artificial sweeteners
□ Fast food
□ Prescription drugs
□ Over-the-counter drugs (i.e. Tylenol, Advil)

____
Total

2. PSYCOLOGICAL STRESS:

□ Relationships
□ Career
□ Children
□ Money
□ Fast-paced life
□ Internalize feelings
□ Procrastinator
□ Sickness or loss of a loved one
□ Perfectionist
□ Quick temper
□ Verbal abuse
□ Nervous / anxious person

____
Total

3. PHYSICAL STRESS:

□ Slips / falls
□ Birth traumas (as a mother or child)
□ Car accidents
□ Knocked unconscious
□ Sports injuries
□ Poor posture
□ Overweight
□ Sitting on your wallet
□ Sleeping position - stomach
□ Extensive computer work
□ Carrying heavy purse / book bag / child
□ Repetitive lifting / bending
□ Continuous sitting / standing
□ Broken bone(s) / surgery
□ Physical abuse
□ Work injuries

____
Total

TOTAL STRESS: _____

(Add checkmarks from bio-chemical, psychological, and physical stresses

MEDICATIONS I AM TAKING

□ Pain Killers (incl. Aspirin, Tylenol, etc.)
□ Muscle relaxers
□ Blood pressure pills
□ Antidepressants
□ Others:_____

FAMILY HEALTH HISTORY

□ Arthritis □ Heart disease
□ High blood pressure □ Diabetes
□ Cancer □ Stroke
□ Others:_____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

□Yes □No Doctors of Chiropractic work with the nervous system?
□Yes □No The nervous system controls all bodily functions and systems?
□Yes □No Chiropractic is the largest natural healing profession in the world?
□Yes □No If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

SYMPTOMS: PAST AND PRESENT

- PLEASE **CIRCLE** ANYTHING WHICH IS CURRENTLY CAUSING YOU PROBLEMS OR HAS BEEN A PROBLEM IN THE PAST 6 MONTHS

GENERAL PROBLEMS
Headache
Fever
Sweats
Fainting
Dizziness
Sleeping problems
Weight Loss / Gain
Depression
Food cravings
Fatigue
Mood swings
Nervousness
Irritability
Tension
Loss of balance

CARDIOVASCULAR
Blood Pressure Problems
Stroke
Heart Condition

MUSCLES & JOINTS
Back Pain / Stiffness
Neck Pain / Stiffness
Numbness in fingers
Numbness in toes
Pins and needles in arms
Pins and needles in legs

EYE/ EAR/ NOSE/ THROAT
Vision problems
Jaw Clicking / Pain
Ringing in ears
Earaches
Frequent Colds
Sinus Problems
Speech Problems
Allergies
Loss of smell
Loss of taste

RESPIRATORY
Chest Pain
Difficulty Breathing
Asthma

GASTROINTESTINAL
Ulcer
Diabetes
Poor / Excessive Appetite
Indigestion
Belching or Gas
Constipation
Diarrhea
Irritable Bowel
Heartburn
Gallstones
Blood in Stool

GENITOURINARY
Problems Urinating
Bed Wetting

G.U. FOR WOMEN
Hot Flashes
Menstrual pain
Menstrual Irregularity
Fertility/Pregnancy Problems

CHIROPRACTIC FEES

CHIROPRACTIC FEE SCHEDULE

• **Consultation**	**No Charge**
• **Assessment and Physical Examination** • Adult / without adjustment • 17 and under / without adjustment	**$99 / $75** **$59 / $40**
• **Subsequent Visit / Spinal Adjustments** • Adult • 17 and under (1st / 2nd / 3rd and subsequent child of the same family adjusted on the same day)	**$47** **$39 / $34 / $29**

All fees payable at time of service
Fees subject to change without notice

If you have extended health benefits through your employer or a private group benefits plan, we may be able to direct bill your insurer.
We will do our best to verify that you have coverage and to inform you when your coverage expires, however you are encouraged to be actively involved with your insurance coverage as **you are <u>always</u> responsible for any charges incurred that are not covered by your insurers.**

☐ Yes, I have extended health benefits ☐ No, I do not have extended health benefits

Plan Member:_____
Insurance Company:_____
Policy Number:_____
Member ID:_____

I understand that by providing this information, I am consenting to have my benefits payable to the servicing provider. In the event that my claim is declined I understand that I will be responsible for any incurred costs.

_____ (Initial)

(Office Use Only)

Patient Name: _____