Guerette Warybrant Clubb
CHIROPRACTIC
1380 London Rd. #39 C Sarnia, ON N7S 1P8 • Tel: (519) 542-5402 • Fax (519) 542-7759 • dquerette@cogeco.net

PATIENT INTAKE FORM

Last Name: _____ First Name: _____

ADDRESS: _____ Postal Code: _____

CITY: _____ Province: _____

Telephone #: _____ Work Phone #: _____ ext. _____

Date of Birth: _____ E-mail: _____
(Day) (Month) (Year)

Referred By: _____ Number of Children: _____

Occupation: _____ Medical Doctor: _____

Closest Relative: _____ Phone Number: _____

Previous Chiropractor: _____ Last Seen: _____

Medications: _____

_____

_____

Surgeries: _____

_____

_____

Is your visit today the result of a: ☐ Workplace Accident or ☐ Auto Accident

Have you ever had any of the following?

☐ Stroke	☐Heart Conditions	☐Arthritis
☐Aneurysm	☐Chronic Illness	☐Rheumatoid Arthritis
☐Diabetes	☐Auto Accident	☐Epilepsy
☐Respiratory Conditions	☐Osteoporosis	☐Other
☐Cancer	☐Hepatitis	

What is your major compliant? _____

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FEE SCHEDULE

The Ontario Health Insurance Plan does NOT cover chiropractic services. Some extended health benefit plans may reimburse you for your visit, due to confidentiality & privacy laws we are unable to look into this for you. Please contact your health benefit provider for more information.

Initial Visit/Consultation/examination (Includes Electrodiagnosis, Neurological & Orthopedic examination)	**$45.00**
Regular office visit (Including adjustments and/or physio)	**$45.00**
Seniors (60 & over)	**$40.00**
Students (Proof of schedule is required)	**$40.00**
Children (16 & under)	**$35.00**

If Special arrangements have been made an outstanding account becomes 90 days past due, action on our part will be required which may result in involving a third party collection agency.

Forms of Payments

Patients are responsible for full payment at the time of service. We accept cash, personal cheques, VISA, Master Card, American Express and Debit. Tap is available as long as your card is set-up to function with it.

Special Arrangements

We have never denied anyone the benefits of chiropractic care due to their inability to pay our published fees. If financial hardship necessitates an individual consideration contract, payment will be handled on an individual basis. Please discuss matters with the office staff.

Patient Agreement

I, _____ have read, understood, and agreed to the above contract.
(Please print name)

_____ _____ _____
Signature of Patient *Office Assistant's Signature* *Date*

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Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by a Doctor of Chiropractic. In particular, you should note:

A. While rare, some patients may experience short-term aggravation of symptoms or muscle and ligament strains or sprains because of manual therapy techniques. Although uncommon, rig fractures have also been known to occur following certain manual therapy procedures;

B. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke; in essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

C. There are rare, reported cases of disc injuries identified following cervical and lumbar spinal adjustment; although, no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustment or other chiropractic treatment.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general (including spinal adjustment), the treatment options and recommendations for my condition and the contents of the consent.

I, _____, consent to the chiropractic treatment offered or
Please Print Name
recommended to me by my chiropractor, including spinal adjustment, various modes of therapy, acupuncture and, if necessary, x-rays for diagnostic purposes. I intend this consent to apply to all my present and future chiropractic care.

_____ _____
Signature of Patient *Witness of Signature (Office Staff)*

_____ _____
Date *Please Print Name*