Heritage Park Physical Therapy

Please Print Clearly ***Please Complete All Information***

Who can we thank for your referral? (internet, friend, family) _____

Name: _____ Birthdate: (mm/dd/yyyy):_____ Gender: M/ F

Address: _____ City:_____ Postal Code:_____

Home Phone:_____ Cell: _____ Work: _____

Email Address: _____
Do we have your permission to send you emails (for appointment reminders, newsletters etc? (Yes / No)

Occupation:_____ Company: _____

Do you have extended healthcare? Yes/ No If yes, who with?_____

Have you had previous chiropractic care? Yes / No When was your last visit?_____

Who is your Medical Doctor? _____

Who is your Massage Therapist? _____Other Healthcare Practitioner?_____

Welcome to Heritage Park Physical Therapy! We want you to understand and consent to the services we provide to you, the costs involved, and what we do with personal inforamtion we obtain about you. If you have questions about any of this, please ask.

Our expectations of patients for services rendered by Heritage Park Physical Therapy:

- We expect all patients to pay for all services when they are provided. If you do not pay for a service at the time it is received, an interest rate of 3% per month will be applied to all outstanding balances and, on default, to pay all costs of recovering debt, including and/ or agent costs.
- We expect all patients to provide **24 hours notice when cancelling an appointment**. Your appointment time is reserved exclusively for you and our professionals cannot use this time to see other patients if you do not provide 24 hours notice or cancellation; you agree to pay our standard fee for the missed appointment, as if you had attended.
- The fee schedule is: New Patient Examinations if $80.00. Subsequent Treatments are $40.00, Acupuncture is $50.00, Comprehensive Treatment $55.00, Re- assessments (greater than 3 months) are $65.00.
- From time to time your Insurance Company may audit you for dates and treatments, signing below gives Heritage Park Physical Therapy permission to release Account Statement information to the company upon their request.

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)

Past Medical History

Any major surgeries or hospitalizations:_____

Lifestyle Factors

Do you smoke? Yes/ No How many packs per day?_____ for _____ years

What do you do for fun? _____ To stay active? _____

Please check any symptoms that you have had in the past or are presently experiencing.
Mark the boxes: C= Current P= Past

MUSCULOSKELETAL	***GENERAL***	***CARDIOVASCULAR***
Low Back Pain	Allergies	Chest Pain
Mid Back Pain	Loss of Sleep	Short of Breath
Neck Pain	Fever	High Blood Pressure
Arm Pain	Headaches	Irregular Heartbeat
Join Pain/ Stiffness	Night Pain	Lung Problems
Problems Walking	Decreased Appetite	Varicose Veins
NERVOUS SYSTEM	Excessive Thirst	Ankle Swelling
Numbness	Frequent Nausea/ Vomiting	Calf Pain
Paralysis	***MALE/ FEMALE***	Stroke/ Heart Pain
Dizziness	Irregular Menstruation	
Forgetfulness	Menstrual Cramps	***GASTROINTESTINAL***
Confusion/ Depression	Vagina Pain/ Infections	Liver Problems
Fainting	Breast Pain/ Lumps	Abdominal Cramps
Convulsions/ Seizures	Prostate Problems	Weight Loss
Tingling	Other	Gas/ Bloating
Loss of Sensation	**EENT**	Heartburn
Stress = Rate your stress level on a scale of 1- 10 (10= highest)	Vision Problems	Black/ Bloody Stool
	Sinus Problems	Colitis
	Ear Aches	Crohn's Disease
	Difficulty Hearing	

Any other medical conditions not listed:

_____

_____

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)

People seek the care of a Chiropractor for many reasons; please check the one that applies to you so we can serve you better.

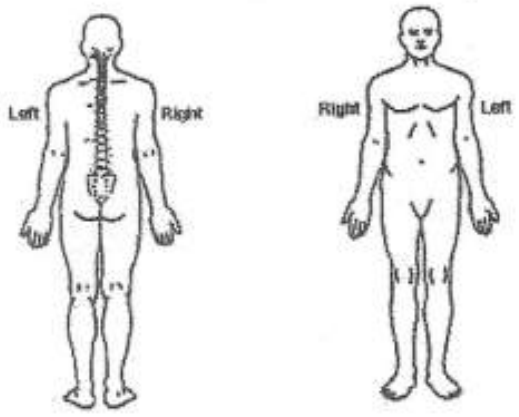
_____ I have a specific problem and only require help with this problem
_____ After my problem, has been relived I want to ensure the problem does not return
_____ Spinal check-up and to improve my general health

Reason for appointment/current complaint: _____

Is this condition: Auto Related / WSIB Claim / Sport Injury / Gradual Onset / Other: _____

Please circle the following diagram based on location of pain or discomfort.

Dull Ache	(A)
Sharp	(H)
Tingling	(T)
Numbness	(N)
Burning	(B)
Stiffness	(F)
Tight	(G)
Other	(X)



Please place an x on the grade indicating the severity of your pain.

(Least) 1 2 3 4 5 6 7 8 9 10 (Worst)

Is your complaint: Constant / Intermitted / Re- Occurring

Have you seen someone else for this condition? _____

Type of Treatment: Results: _____

Current Medications: Pain Killers / Muscle Relaxants / Blood Pressure / Insulin / Anticoagulants

Please List: _____

Any other questions, comments or concerns? _____

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)

Heritage Park Physical Therapy

Consent to Chiropractic Treatment

It is important for you to consider all 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 timeline, 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 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 alternative to treatment. I hereby consent to chiropractic treatment as proposed to me.

Name (Please Print) _____

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)

_____ Date: _____ 20_____

Signature of Chiropractor