Oxford Wellness Clinic

15152 127 Street NW Edmonton, AB T6V0C5
Phone: 780.758.8323 Fax: 780.669.5829
www.oxfordwellnessclinic.ca

Name:____________________/____________________/__________ Gender: M / F

Last First Middle

Address:____________________/__________/__________/__________

Street City Prov Postal Code

Date of Birth (DD/MM/YYYY): ____________________/ Age: ________/ Height: _______/ Weight: _______

Phone (Home) (____) __________________

Phone (Cell) (____)__________________

Phone (Work) (____)__________________

Email: ______________________________

Occupation: ______________________________

Referred by: ______________________________

Relationship to you: __________________________

Alberta Health Care #: ____________________

Insurance Company: ____________________

Claim / ID #: ________________________

Plan / Group #: ________________________

Cardholder Name: ______________________

EMERGENCY CONTACT INFORMATION

Name: ______________________________

Phone Number: __________________________

Relationship: ____________________________

Family Doctor Contact Info: ____________________

*To receive text/email reminders please circle either: EMAIL or TEXT Cell phone service provider: ______________

Initial Assessment and Treatment	**$120.00**
Reassess Fee (inactive for 6 months)	**$80.00**
Subsequent Chiropractic Visit	**$65.00**
Orthotics	**$500.00**

Visit may include but is not limited to:

-Consultation -Adjustment -Joint work -Exercise-Muscle release therapy -Electro therapy

Full balance of fees are due and payable at the time of service.
*Oxford Wellness Clinic has a **24 hour** cancellation policy. A **$25 charge** for a late appointment cancellation and a **$50 charge ($100 for an Initial Visit no show)** for a no show will be applied to your account. Thank you for your understanding and respecting your therapists' time, as we continue to serve you with the utmost care.*

Date: __________________________ *Patient Signature:* ______________________________

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Reason(s) for appointment: ____

When did your condition begin? ____

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No Which tests, when? ____________________

____

____

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No Date of Accident: ____________________

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? ____

List all previous surgeries, illnesses, injuries (including MVA): ____

____

____

____

Please list all medications (over the counter, prescriptions, supplements, vitamins, herbal supports, aspirin, etc.): ________

____

____

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. ____________________ Date: ____________________

ORTHOTICS :

Do you currently use custom foot orthotics/insoles? ☐ Yes ☐ No ☐ Unsure

Would you like to be fitted during a future visit? ☐ Yes ☐ No

Date: ____________________ Patient signature: ______________________________

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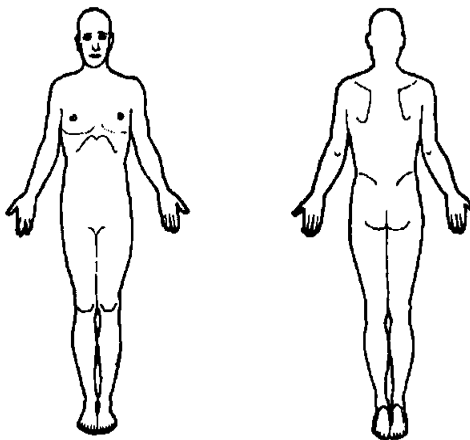
Health History Questionnaire

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure -- Yes No
2. Hardening of the arteries (arteriosclerosis)-- Yes No
3. Diabetes--- Yes No
4. Tuberculosis-- Yes No
5. Cancer -- Yes No
   Where? ____
6. Heart or blood diseases --- Yes No
7. Bone spurs on the neck bones (cervical sprain) -- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)-------------------------------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ------------------------------- Yes No
10. Were you ever a smoker? --- Yes No
    From ______________________ to ___________________
11. Do you take medication on a regular basis? --- Yes No
12. Visual disturbances (blurring, loss, double vision)-- Yes No
13. Hearing disturbances (loss, ringing, other noise) --- Yes No
14. Slurred speech or other speech problems -- Yes No
15. Difficulty swallowing --- Yes No
16. Dizziness --- Yes No
17. Loss of consciousness, even momentary blackouts --- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ------------------------------ Yes No
19. Sudden collapse without loss of consciousness--- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain

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GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hands or feet	Gallbladder/Jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders	Birth control pills
Enlarged glands	Swollen joints	Miscarriages
	Spinal curvature	Complications with pregnancy
	Arthritis	Pregnant? Y / N Week?
	Fractures	Other:

Systems Review Circle any conditions that are presently causing you a problem.
Underline those that have caused you problems in the past.

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Electronic Transmission Authorization and Consent Form

Message to the Plan member, Spouse and/or Dependent regarding Personal Information Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
  exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider{s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

Date: ______________________ Patient Signature: _________________________

Print Name: _______________________________

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As a courtesy to our patients, our clinic provides direct billing to selected insurance providers that allow electronic submissions and direct billing. It is to the discretion of your insurance provider to proceed with this approval. For any questions regarding your benefits, please contact your insurance provider directly as this is private and privileged information.

*It is imperative that this **INSURANCE BENEFITS FORM** is returned to our clinic ASAP in order to properly complete this process for you, our valued patients. Please fill this form in accurately and in full in order to update your file.*

Date: ______________________________

Plan Member Name: ______________________________ DOB: ________________ Contact Number: ____________________

Patient Name: ______________________________

Insurance Company: ______________________________
Claim/ID #: ______________________________
Group/Policy #: ______________________________

Annual Rollover Date: ______________________________________

CHIROPRACTIC

Total coverage per year: _$___________________

Maximum coverage per visit: ________________%___

MASSAGE THERAPY

Total coverage per year: _$___________________

Maximum coverage per visit: ________________%___

Is a doctor's referral/prescription required? YES / NO

ORTHOTICS

Total coverage per year: _$___________________

Maximum coverage per visit: ________________%___

Is a doctor's referral/prescription required? YES / NO

PHYSIOTHERAPY

Total coverage per year: _$___________________

Maximum coverage per visit: ________________%___

ACUPUNCTURE

Total coverage per year: _$___________________

Maximum coverage per visit: ________________%___