Welcome to Our Office

Outline of Procedures for New Patients:

Step 1

All new patients are requested to fill out a confidential **"Patient Health Record"**.

Step 2

Your first **"Consultation"** with the doctor to discuss your health problems.

Step 3

You will receive a **"Chiropractic Examination"** to determine if chiropractic care is appropriate for your condition.

Step 4

An assessment of your musculoskeletal system and nervous system. As well, if indicated, **x-rays** will be ordered or taken to visualize the location of your problems, and/or a **Posture Screen analysis** to study your actual posture.

Step 5

If your case requires immediate attention, **first day Chiropractic manual care and other procedures** will be utilized to address your concerns.

Step 6

You will be advised as to a time you can return for your **"Report of Findings"** when your doctor will inform you as to your examination results. If we can help, your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate

Step 7

Chiropractic care will begin and continue as scheduled until the maximum possible improvement has been obtained.

Step 8

Website Membership Enrollment: The information on our website will help you gain more control over your health. Please provide your email address so we can establish you as a member of our website today. Please check the health subjects that most interest you:

☐ Headaches and Neck Pain ☐ Backaches and Sciatica ☐ Exercise to Strengthen and Fitness
☐ Diet and Nutrition ☐ Stress Reduction Strategies ☐ Ergonomics

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt out at any time. Please review our complete privacy policy on our website.

☐ I would like to receive newsletters by e-mail ____________________________

Email Address____

To save time and allow us to better serve you, please complete all questions on the next pages. Thank you!

Personal History

Name: ______________________ Address: ______________________
City: ______________________ Province: ______________ Postal Code: __________
Home Phone: ______________________ Birthdate: DD / MM / YYYY Age: ____ Sex: ☐ M ☐ F
Cell Phone: ______________________
Business/Employer: ______________________ Business Phone: ______________
Type of Work: ______________________
Circle One: Married Single Widowed Divorced Separated Other Number of Children: __________
Emergency Contact: ______________ Phone Number: __________ Relationship: __________
How were you referred to this office? ☐ Yellow Pages ☐ Website ☐ Friend/Family Member ☐ Physician
Who may we thank for referring you to this office? ______________________
How will you be paying your account? ☐ Visa ☐ Mastercard ☐ Cash ☐ Cheque ☐ Interac ☐ Other

Current Health Condition

Current Complaint(s): ______________________
Other doctors seen for this condition? ☐ Yes, ☐ No Who? ______________________
Type of Treatment: ______________________ Results: ______________________
When did this condition begin? ______________ Has the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: __________
Date of Accident: ______________________ Time of Accident: ______________________
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: __________
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: ______________________
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better?
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent
Please describe how it feels when this problem is at its worst: ______________________
____
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 take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Name all medications if known: ______________________
____
Do you suffer from any other condition than the one you are now consulting us for? ______________
____
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: __________

Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where? ______________________

Past Health History

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

Previous: Childhood Traumas ☐ ____________________ Sports Injuries ☐ ____________________
Motor Vehicle Accidents ☐ ____________________ Work Injuries ☐ ____________________

Hospitalization (other than above): ____

____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: ______________________________________
Approximate Date of Last Visit: ___________________________

Family Health History

Name of Family Physician: __________________ ☐ I do not have a Family Physician ☐ I attend walk-in clinics

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 been seen by a chiropractor or physiotherapist? No ☐ Yes ☐ If yes,
where and when? ____

Below is a list of diseases which 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 care.

Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculoskeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Females Only

When was your last period?

____

____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Satisfaction with Diet

☐ Highly Satisfied
☐ Dissatisfied
☐ Highly Dissatisfied

Do you have a regular exercise program?

☐ Yes
☐ No

If yes, where? ______________

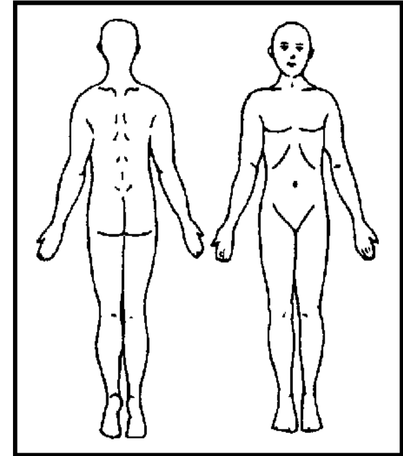
Lifestyle Stress Levels

☐ High
☐ Moderate
☐ Very Little

Check any of the following diseases you have had:

☐ Pneumonia
☐ Mumps
☐ Influenza
☐ Rheumatic Fever
☐ Smallpox
☐ Pleurisy
☐ Polio
☐ Chicken Pox
☐ Arthritis
☐ Tuberculosis
☐ Diabetes
☐ Epilepsy
☐ Whooping Cough
☐ Cancer
☐ Mental Disorder
☐ Anemia
☐ Heart Disease
☐ Lumbago
☐ Measles
☐ Thyroid
☐ Eczema

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



Why Chiropractic, Physiotherapy, Registered Massage Therapy and Acupuncture as a Chiropractic Adjunctive Therapy?

People go to a Chiropractor or Physiotherapist or Massage Therapist for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others find it necessary to return for care off and on as their condition deteriorates over time if left untreated. (Supportive Care) Supportive Care is necessary care to improve one's condition back to what it was when at its maximum recovery prior to it deteriorating subsequent to your physical demands. How long you choose to benefit from Care is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Supportive Care
☐ Rehabilitative Care
☐ Relief Care
☐ Check here if you want the doctor to select the type of care appropriate for your condition.

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of assessments, chiropractic adjustments, physiotherapy, registered massage therapy, acupuncture as an adjunctive therapy and other chiropractic procedures, including various modes of physical therapy, laser therapy and other procedures, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the chiropractor/ physiotherapist/registered massage therapist / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments physiotherapy, registered massage therapy, acupuncture as an adjunctive chiropractic service and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic and physiotherapy there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. When used in combination with certain medications laser therapy can cause burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. I also understand that the laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic and Physiotherapist for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

_____________________________________ Patient Signature

____________________ Date