WELCOME TO THE MARTIN CHIROPRACTIC CLINIC

Let me extend a warm and personal welcome to you on behalf of the staff and myself.

In a few moments, I'll get to meet you and discover how we may be able to help you with safe and natural chiropractic care.

FIRST VISIT

At your first visit we will gather information about you through our questionnaire, consultation and examination. When you have completed the forms, you will be escorted to a treatment room. My assistant will review your history with you. You will be asked to change into appropriate attire for your examination. I will study your history and then conduct a complete spinal examination. If x-rays are warranted you will be instructed on how to obtain these.

REPORTING VISIT

At your next visit we will discuss our examination findings, if applicable, your x-rays, and any diagnostic/clinical information provided. No treatment will be rendered without your complete understanding and permission.

PATIENT EDUCATION

We will be giving you information and clinical data in the form of literature, personal and media presentations. These are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

Since we are going to ask you some personal information, it's only fair that I reveal some information about myself and my staff.

I was introduced to chiropractic during my early university years. I had tried traditional approaches to resolve my constant headaches and it wasn't until I visited a chiropractor that I got relief. That inspired me to choose a career in chiropractic.

I married my wife Jen in 1990. My son Joel was born in 1992 and my daughter Claire in 1995.

I continue to see my own chiropractor regularly and routinely check the spines of my family members. It keeps our spine and nervous systems functioning optimally as well as our immune systems. Since starting my practise in 1986, I have missed only a half day to illness.

THE CLINIC STAFF

The clinic staff has been carefully selected on the bases of their education, experience and caring personality. Our staff have a clear understanding of chiropractic principles and all personally enjoy the benefits of a chiropractic lifestyle. Together we all take part in on-going chiropractic and clinical education opportunities.

HEALTH ATTITUDES

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. **Please** mark the **ONE ONLY** that most closely reflects your personal values.

☐ **Treatment Only** - I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.

☐ **Prevention** - In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

☐ **Maintaining Health** - I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential

☐ **Family Health** - I take an active part in assisting, informing, and maintaining health, with my family. I am concerned with the long-term effects of good health.

Thanks for visiting us today. I look forward to meeting you and seeing how we can help you achieve your individual health goals.

J. Scott Martin, D.C.

CASE HISTORY:

DATE: _____

NAME: _____
(LAST NAME) (Exactly as it appears on your Health Card) (FIRST NAME) (INITIAL)

ADDRESS: _____ CITY: _____ POSTAL: _____

HOME PHONE # _____ ***STUDENTS: INDICATE ON NEXT LINE IF YOUR HOME ADDRESS IS DIFFERENT THAN ABOVE***

_____

DATE OF BIRTH: _____ MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

YOUR OCCUPATION _____ YOUR EMPLOYER _____

WORK PHONE # _____ EXT _____ E-MAIL _____ CELL # _____

SPOUSE'S NAME: _____ OCCUPATION: _____ # OF CHILDREN _____ AGES _____

DO YOU HAVE EXTENDED HEALTH CARE INSURANCE? YES ☐ NO ☐ INSURANCE COMPANY? _____

YOUR DOCTOR: _____ DOES HE/SHE KNOW YOU ARE SEEKING CHIROPRACTIC CARE? YES ☐ NO ☐

HAD PREVIOUS CHIROPRACTIC CARE? YES ☐ NO ☐ IF YES, WHEN _____ WHERE? _____

CHIROPRACTORS NAME _____ YOUR LAST CHIROPRACTIC TREATMENT? _____

HOW DID YOU HEAR OF OUR CLINIC? _____

ABOUT YOUR HEALTH: *The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your full health potential.*

LOSS OF WELLNESS: *Let's begin at birth when you first could have damaged your nerve system, lost your wellness and began your journey to ill health:*

#1 YOUR BIRTH PROCESS: (please check ✓)
(If you were told about it)

When you were born...

YES	NO	
☐	☐	-was delivery long?
☐	☐	-were forceps used?
☐	☐	-was it a home birth?
☐	☐	-was labour induced?
☐	☐	-was it a difficult delivery?
☐	☐	-was it a caesarean/breach/cephalic?
☐	☐	-were there any complications?
☐	☐	-was mom given drugs during delivery?

#2 YOUR GROWTH AND DEVELOPMENT: (please check ✓)

As a child/teen, were you...

YES	NO	
☐	☐	-taught how to care for your spine?
☐	☐	-picked on by your siblings?
☐	☐	-pulled by the arm, ear or chin?
☐	☐	-frequently spanked?
☐	☐	-in any accidents? _____
☐	☐	-injured? _____
☐	☐	-did you regularly use medications? if so, what? _____
☐	☐	-did you fall out of bed?
☐	☐	-did you fall down the stairs?
☐	☐	-did you have a chair pulled from beneath you?
☐	☐	-did you suffer childhood abuse?
☐	☐	-did you stumble/fall frequently?

#3 YOUR HEALTH STATUS NOW: (please check ✓)

YES	NO	
☐	☐	-do you smoke/drink alcohol?
☐	☐	-involved in any auto accidents? -Injury? _____
☐	☐	-involved in sports accident? -Injury? _____
☐	☐	-teeth or jaw problems? Explain: _____
☐	☐	-have nightmares/poor sleep?
☐	☐	-have stress?

if so, what kind? Physical ☐ Mental ☐ Occupational ☐

☐	☐	-eat healthy food?
☐	☐	-any know allergies? What? _____
☐	☐	Eye, Ear, Nose problems? Explain: _____

Sleeping Position? Side: ☐ Back: ☐ Stomach: ☐
Mattress Type? Regular: ☐ Futon: ☐ Contour: ☐ Other: ☐
Pillow Type? Foam: ☐ Feather: ☐ Fibre: ☐ Other: ☐

YOUR COMPLAINT TODAY?

_____
_____
_____

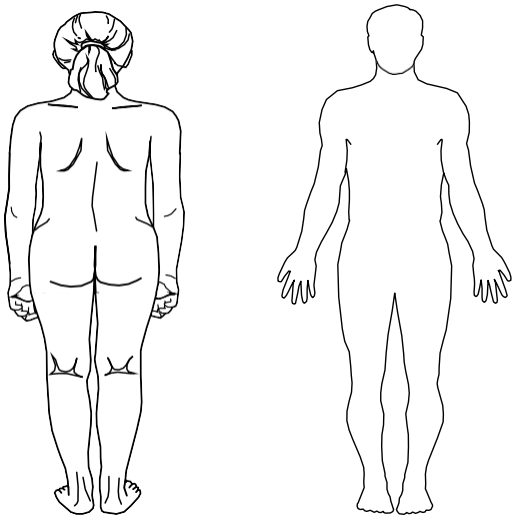
WHEN DID YOUR PROBLEM BEGIN?

_____
_____

PLEASE MARK THE DRAWING WITH THE SYMBOL THAT APPLIES:

Mark "X" where you have *PAIN*
Mark "L" where you have *LOSS OF FEELING*
Mark "T" where you have *TINGLING*

Back: **Front:**



Is it getting worse? Yes ☐ No ☐
Have you experienced this problem before?
Yes: ☐ No: ☐ When? _____

Have seen other health providers for ***this*** problem?
Yes: ☐ No: ☐ Who? _____
When? _____

X-Rays/Tests taken: Yes ☐ No ☐ _____

When?_____Standing ☐ Laying ☐

List any surgery(s) you have had and When? _____
_____
_____

Are you presently under medical care? Yes ☐ No ☐
Condition(s): _____
_____

Drugs currently taking: _____
_____

Is there a family history of? Heart Disease ☐ Cancer ☐
Arthritis ☐ Diabetes ☐ Stroke ☐ Other ☐

DESCRIPTION OF SYMPTOMS:
Pain(s) are? Sharp ☐ Dull ☐ Both ☐

DURATION OF PAIN: Constant ☐ Intermittent ☐

AGGRAVATED BY: _____
_____

LESSENED BY: _____
_____

Worse certain times of day?
YES ☐ NO ☐ AM ☐ PM ☐

Getting Worse ☐ Same ☐ Improved since onset? ☐
Interfering with? Work ☐ Sleep ☐ Routine ☐
Other activities? ☐ _____

What home remedies have you tried? _____
_____
_____

Please Indicate Symptoms with Check ✓

Are you experiencing...	***Now***	***In the past***
Headache	☐	☐
Neck Pain/Stiffness	☐	☐
Numb Fingers	☐	☐
Pins/Needles Arms	☐	☐
Cold Hands	☐	☐
Ears Ring/Buzz	☐	☐
Lights Bother Eyes	☐	☐
Loss of Taste/Smell	☐	☐
Loss of Balance	☐	☐
Loss of Memory	☐	☐
Sinus	☐	☐
Fainting/Dizziness	☐	☐
Shortness of Breath	☐	☐
Upper Back Pain	☐	☐
Chest Pain	☐	☐
Lower Back Pain	☐	☐
Pins/Needles Legs	☐	☐
Numb Legs/Feet/Toes	☐	☐
Cold Feet	☐	☐
Diarrhea/Constipation	☐	☐
Upset Stomach	☐	☐
Respiratory Problems	☐	☐
Fatigue	☐	☐
Depression/Irritability	☐	☐
Nervousness/Tension	☐	☐
Fever	☐	☐

ABOUT YOUR CARE:
Chiropractic provides three types of care:

- *The first is **INITIAL INTENSIVE CARE** which corrects the most recent layer of spinal and neurological damage Vertebral Subluxation Complex (VSC). This usually reduces or eliminates the symptoms.*
- *Then begins the **RECONSTRUCTIVE CARE** which corrects the long term changes that have occurred when there were few symptoms.*
- *And finally, chiropractic offers a genuine approach to **WELLNESS CARE.***

All of these options will be explained at your Report of Findings visit. Then you'll be able to begin a course of care that fits your health goals.

PRIVACY ACT: Consent for Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. It is important to us to provide this service to our patients.

In this office, Mrs. Donna Culver acts as the Privacy Information Officer. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

-only necessary information is collected about you,

-we only share your information with your consent,

-storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;

-our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff. Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses Patients' Personal Information

To help you understand how we are using and disclosing your personal information please read the outline below;

-to deliver safe and efficient patient care

-to identify and to ensure continuous high quality service

-to assess your health needs

-to provide health care

-to advise you of treatment options

-to enable us to contact you

-to establish and maintain communication with you

-to offer and provide treatment, care and services

-to communicate with other treating health-care providers, including specialists and referring doctors

-to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments

-to allow us to efficiently follow-up for treatment, care and billing

-for teaching and demonstrating purposes on an anonymous basis

-to complete and submit claims for third party adjudication and payment

-to comply with legal and regulatory requirements, including the delivery of patients=charts and records to governing bodies in a timely fashion when required, according to the provisions of the Regulated Health Professions Act

-to comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients charts and records in a timely fashion for regulatory and monitoring purposes

-to permit potential purchasers, practice brokers or advisors to evaluate the practice

-to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale

-to deliver your charts and records to the office=s insurance carrier to enable the insurance company to assess liability and quantify damages, if any

-to prepare materials for the Health Professions Appeal and Review Board (HPARB)

-to invoice for goods and services

-to process credit card payments and collect unpaid accounts

-to assist this office to comply with all regulatory requirements

-to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act RHPA) and for the defence of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how our office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at anytime. I agree that J. Scott Martin, D.C. or Martin Chiropractic Clinic can collect, use and disclose personal information about the patient signing below as set out above in the information about the office=s privacy policies.

_____

(Signature of Patient)

_____

(Witness)

Dated:_____