ROBICHAUD
chiropractic + orthotics
www.DocAdrian.com

Fill in pages 1 and 2, read page 3, but don't sign yet.

CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Date: _____

Address: _____
Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: ( )_____ Cellular Telephone Number: ( ) _____

Email:_____ Birth date: _____ Biological sex: _____

Occupation: _____ Employed by: _____

Do you have insurance benefits? ☐Yes ☐No Company: _____

☐Single ☐ Married/Common-law ☐Separated ☐ Divorced ☐ Widowed

Have you had previous chiropractic care? ☐Yes ☐No Chiropractor's name:_____

Medical Doctor's name and phone number: _____

Whom may we thank for referring you to our office?_____

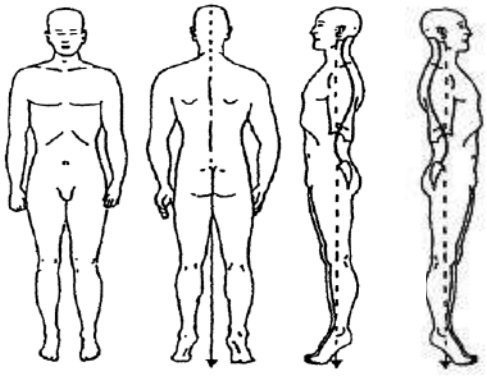
YOUR HEALTH PROFILE

Please briefly describe the chief area of complaint, including the effect it has had on your life, when you first noticed it, and how it originally occurred.

_____

_____

Indicate where you feel your symptoms on the diagram below:



Check the boxes that describe what you are feeling:

☐ Dull ☐ Sharp ☐Numbing ☐Throbbing ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Cramping ☐Cutting

☐Stiff ☐Spasms ☐Stinging ☐Shooting ☐Pounding ☐Constricting ☐ Other:_____

When did it start? _____ It is: ☐About the Same ☐Getting Better ☐Getting Worse

What makes it worse? _____

How frequent is the complaint? ☐Constant ☐Daily ☐Intermittent ☐Night Only ☐ Other: _____

How long does it last? ☐ All day ☐A Few Hours ☐ Minutes ☐ Seconds

Is there anything you can do to relieve the problem? ☐Yes ☐No If yes describe: _____

It Interferes with: ☐Work ☐Sleep ☐Walking ☐Sitting ☐Hobbies ☐Leisure

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Name:_____

Please indicate your level of pain/discomfort below by checking a number/circling a word:

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

Normal *Mild* *Moderate* *Severe* *Excruciating*

*If your pain varies or you have multiple areas of pain at different levels, inform the doctor.

Please check (√) all symptoms you have had in the past year even if they do not seem related to your current problem.

☐Headaches
☐Neck Pain/ Stiffness
☐Pins & Needles in Arms
☐Pins & Needles in Legs
☐Numbness in upper limb
☐Numbness in lower limb
☐ Clinical Depression
☐Severe Menstrual Pain
☐Menstrual Irregularity

☐Loss of Taste
☐Hypersensitive Eyes
☐Buzzing/ringing in Ears
☐Significant Irritability
☐Mood Swings
☐Severe Nervousness
☐Considerable Fatigue
☐ Severe Constipation
☐ Severe Diarrhea

☐Significant Tension
☐Fainting
☐Dizziness
☐Back Pain
☐Cold Hands
☐Loss of Balance
☐Fever in the past month
☐Loss of Smell
☐Cold Feet

☐Problem Urinating
☐Heartburn
☐Ulcers
☐Upset Stomach
☐Hot Flashes
☐Sleeping Problems
☐Cold Sweats

Please note any major illnesses you have had: ☐Heart disease ☐Cancer ☐Diabetes Other: _____

_____

Please list any major accidents or surgeries you have had and when you had them: _____

_____

Please list any medications you are taking: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me/my child for further evaluation. Please do not sign until you see the doctor.

Signature of Patient/Legal Guardian: _____ Date:_____

OUR FEE SCHEDULE

Initial Assessment..... **$75.00**
Subsequent Visit..... **$40.00**
Reassessment..... **$55.00**

Student/ Senior (65 and older)Child (under 16)

Same as above. We do not have separate fees for Seniors/students or children. Fee discounts are considered on a case-by-case as-needed basis.

Custom Made Orthotics

1 Pair of Custom Fitted Orthotic Inserts..... **$500.00**
1 Pair of Custom Fitted Orthotic Shoes/Sandals... **$600.00**

Payment is due when the service is rendered. We will provide receipts upon your request. Please note that many private insurance companies pay towards chiropractic care and custom made orthotics. Please consult your insurance plan for more details. If you have been injured at work or involved in a recent automobile collision, please let us know so we can arrange to bill on your behalf.

I have read and understand the fee schedule.
Signature of Patient/Legal Guardian:_____ Date:_____

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NOTE TO PATIENT: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

I, _____ have read the below statement and consent to treatment:

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or strokes like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in five million. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions.

While rare, some patients have experienced rib fractures or muscle strains and/or ligament sprains following spinal adjustments.

Wearing custom orthotics may result in an increase in your symptoms and in rare cases fracture of foot bones or sprains and strains of the feet and other ligaments and muscles in the body, especially if worn incorrectly or contrary to the doctor's dispensing instructions.

I understand all accounts are payable when service is rendered.

I understand that to provide me with health goods and services, Dr. Adrian Robichaud will collect some personal information about me (e.g., home telephone number, address).

I understand that Dr. Adrian Robichaud has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.

I understand that I may receive the following: newsletters, thank you cards, birthday cards, phone calls, health packages etc. that may be of interest to me.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Dr. Adrian Robichaud collecting, using, and disclosing personal information about me as set above and in Dr. Adrian Robichaud's Privacy Policy.

I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my case, specifically, other healthcare practitioners or my insurance provider, and do hereby hold harmless anyone from such actions.

Signature of Patient (or legal guardian): _____

Signature of Witness: _____ Witness Name:_____
Please print name above

Date: _____