DOUGLASDALE FAMILY CHIROPRACTIC

Adult Introduction Form

Today's Date: _____

AHC#: _____

Last name: _____

First name: _____

Date of birth: _____ Current age: _____

Marital status: S M C-L D W Gender: Male Female

# of Children: _____ Their ages: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Home phone number: _____

Cell phone number: _____

Email address: _____

Would you like to opt-out of receiving our monthly wellness newsletters? Yes No

Occupation/Employer: _____

Emergency contact: _____

Emergency contact number: _____

Previous chiropractor: _____

Date of last visit: _____

Who may we thank for referring you? _____

Physical History: Please tell us what brought you into our office.

Wellness Maintenance Specific Symptom Auto Accident

If you currently have specific symptoms, what is your major complaint?

_____

How long has it been since you really felt good? _____

What is the goal that you would like to achieve by having your optimum health restored? _____

_____

Please list any of the following injuries:

Auto: _____ Sports: _____

Work: _____ Other: _____

Chemical History: Please list any current medication, pain-killers and/or supplements: _____

_____

Emotional History: Please let us know about any recurring stress, loss or abuse in your life that you feel we may need to be made aware of?

_____

Please check any of the following symptoms that you presently have or have experienced in the past:

Eyes, Ears, Nose & Throat:

- ☐ Colds _____ times per year
- ☐ Ear ringing / aches / discharge
- ☐ Nasal obstruction
- ☐ Sinus infection
- ☐ Enlarged glands
- ☐ Difficulty swallowing
- ☐ Tonsillitis
- ☐ Eye pain
- ☐ Double / blurred / loss of vision

Neurological:

- ☐ Allergies
- ☐ Seizures
- ☐ Dizziness
- ☐ Abnormal loss of weight
- ☐ Fainting / concussions
- ☐ Tremors
- ☐ Headaches / migraines
- ☐ Loss of sleep
- ☐ Nervousness / depression

Respiratory:

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Spitting Blood
- ☐ Asthma

Pain or Numbness In:

Left	Right	Shoulder
Left	Right	Arm
Left	Right	Elbow
Left	Right	Hands
Left	Right	Fingers
Left	Right	Hip
Left	Right	Knee
Left	Right	Foot
Left	Right	Toes

- ☐ Low back pain
- ☐ Neck pain / stiffness
- ☐ Tailbone pain
- ☐ Pain between shoulders
- ☐ Muscle cramping
- ☐ Jaw problems

Gastrointestinal:

- ☐ Constipation / diarrhea
- ☐ Difficult digestion
- ☐ Nausea
- ☐ Stomach pain

Other Conditions:

- ☐ Cancer
- ☐ Herniated / degenerated disc(s)
- ☐ Heart disease
- ☐ High blood pressure

Genitourinary:

- ☐ Diabetes
- ☐ Abnormal urine / urination
- ☐ Frequent urination (>20x/day)
- ☐ Lack of control of urination
- ☐ Kidney infection
- ☐ Prostate troubles

Women Only:

- ☐ Cramps
- ☐ Irregular flow
- ☐ Irregular / painful cycle
- ☐ Abnormal discharge
- ☐ Sore breasts
- ☐ Menopause
- ☐ Pregnant: due date: _____
- ☐ Last menstruation: _____

Please list any other problems that you have or have been seeing your family doctor for: _____

_____

Health and Wellness:

Are you interested in learning more about the other services offered in the office?

- ☐ Nutritional Support
- ☐ Physiotherapy
- ☐ Massage
- ☐ Traditional Chinese Acupuncture
- ☐ Custom Orthotics

Your personal information will be held in the strictest confidentiality and is used only for the clinical purposes at Douglasdale Family Chiropractic. If you have any areas that you are not comfortable discussing or that require further confidentiality, please speak directly to the Doctor about them.

Douglasdale Family Chiropractic
Our Policies & Commitments

Welcome to our office! We thank you for choosing us.

Mission Statement

Our Mission is to inspire families to value health as their highest priority.

OUR COMMITMENTS TO YOU:

1. Optimize nerve function.
2. Educate you and your family about health, healing, and well-being.
3. Create a program of care that meets your personal goals and timetable.
4. Run the office on time.
5. Book extra time on request to answer any additional questions you may have.
6. Be flexible whenever possible if appointments need to be changed.

YOUR COMMITMENTS TO US:

1. Keep your appointments, as each adjustment builds on the one before.
2. Give 24-hour notice for an appointment change, whenever possible. (We reserve the right to bill your account $25 if notice is not given).
3. Rebook cancelled appointments to keep on track with your care plan.
4. Arrive on time for each of your scheduled appointments.

Fees:

Douglasdale Family Chiropractic operates on a **fee for service basis** and fees are due at time of care. Fees for chiropractic services are as follows:

Service	Price	Includes:
Initial Adult Exam	$100	Covers consultation, examination, spinal scans and a report of findings with the chiropractor (x-rays if necessary).
Initial Infant/Child Exam	$110	Covers consultation, examination and first adjustment (x-rays if necessary).
Regular Visit	$60	Adjustment
Senior Visit (65+)	$50	Adjustment
Re-Examination / Re-Entry Visit	$30	Patients who have not been in for over 6 months or have sustained a new injury / accident.
Re-Scan	$30	A chiropractic exam and spinal scans to establish patient progress.
After Hours Emergency	$120	
Custom Orthotics	$475	Orthotic scan, and report of findings included.

Extended Health Benefits: We direct bill to most insurance companies for your primary insurance only.
We direct bill for motor vehicle accidents within the first 90 days post-accident and will fill out all required forms.
Please Note: We are **not a WCB authorized chiropractic provider.

Accuracy of Information

I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I have read all the above office policies and understand and accept my responsibilities as a practice member.

Signature: _____ Date: _____