Whitby Chiropractic & Integrated Health Services
Dr. Brian R. Biastoch, DC, HonBsc
420 Green Street, Unit 103
Whitby, On
L1N 8R1

Date	Patient No.

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Birthday: _____ Age: _____ Sex: Male / Female
Cell Phone: _____ Health Card #: _____
Business / Employer: _____ Type of Work: _____
Business Phone: _____ Email Address: _____
Circle One: Married Single Divorced Separated No. Of Children: _____
Name/ Number of Emergency Contact: _____ Relationship: _____
Who may we thank for referring you to this office? _____
How will you be taking care of your account? Cash ☐ Cheque ☐ Credit Card ☐ 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 this condition occurred before? ☐ Yes ☐ No
Is 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

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Current Health Condition Continued

Please describe how it feels when this problem is at its worst: _____

Please circle to indicate your pain severity Least 1 2 3 4 5 6 7 8 9 10 Worst

Compare this problem at its worst and at a time when you feel great. How does this problem at its worst 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 it make you feel?_____

If you don't get this problem corrected, do you think it will get worse over the next five years? ☐ Yes ☐ No

Drugs you now take: ☐ Nerve Pills ☐ Painkillers / Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

☐ Other: _____

Do you suffer from any condition other than that for which you are now consulting us? _____

_____

On a scale of 1-10, 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

Please check or describe:

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 and approximate last visit:_____

_____

Family Health History

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom?_____

Have your children ever had a spinal check-up? ☐ No ☐ Yes If yes, where and when?_____

_____

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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 chiropractic care.

Check any of the following diseases you have had:

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

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

Musculo-Skeletal Code

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

Nervous System Code

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

C-V-R Code

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

General Code

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

EENT Code

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Stuffed Nose

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Gastro-Intestinal Code

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

Male / Female Code

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

Genito-Urinary Code

☐ Bladder Trouble ☐ Discolored Urine ☐ Painful / Excessive Urination

Females Only

When was your last period? _____
Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

Intake

☐ Coffee ☐ Cigarettes
☐ Tea ☐ White Sugar
☐ Alcohol

Personal Satisfaction with Diet

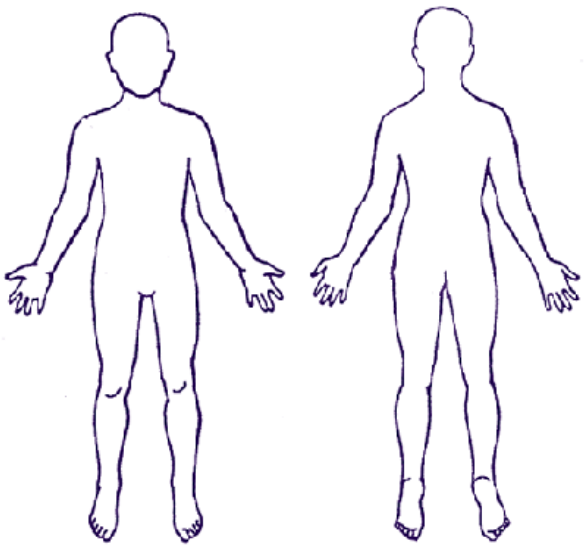
☐ Highly Satisfied ☐ Dissatisfied ☐ Highly Dissatisfied

Do you have a regular exercise Program?

☐ Yes ☐ No

Lifestyle Stress Levels

☐ High ☐ Moderate Very Little ☐



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

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Consent To Chiropractic Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits
Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks
The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:
● **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
● **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
● **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
● **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
● **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

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● **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives
Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

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E-Newsletter Subscriber Enrollment

As an extension of the care you receive in our practice, may we add you as a subscriber to our website to receive emails and important COVID-19 updates that will help you get well and stay well. Naturally you can unsubscribe at any time.

First name :_____

Last name :_____

Gender : Male Female

Date of birth : _____ / _____ /_____

Email address : _____

Consent to receive e-newsletters: Yes No

TELUS Health

Electronic transmission authorization and consent form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider		
First and last name or clinic name		
Address		
City	Province	Postal code
Patient		
First name	Last name	
Primary coverage insurer/payer	Primary coverage plan member name	
Primary coverage policy number (also referred to as group or contract number)		
Primary coverage certificate (also referred to as member/identification number)		
(Canada Life only) secondary coverage plan member name		

Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

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 such 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, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and 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.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any 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 employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

☐ **I accept the terms and conditions**

Benefit assignment form

I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by my healthcare provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the healthcare provider.

☐ **I accept the terms and conditions**

_____ _____

Date Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.