

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

A Chiropractic Health Assistant will perform some computerized testing with prior to seeing one of our doctors. An in-depth, technologically-advanced assessment of your nerve and energy system is conducted to determine how well your brain is communicating with your body. Any interference to this communication can be measured by **surface electromyography** which studies muscle function and **dermothermography** which illustrates inflammation. **Ranges of motion** are also tested and **bilateral weight scales** determine weight distribution asymmetries indicative of spinal abnormalities, and a **computerized gait analysis** studies the effects on posture.

Step 3

A "Consultation" with the doctor to discuss your health problems.

Step 4

A "Chiropractic Examination" is performed to determine if chiropractic care is appropriate for your condition. As well, if indicated, a referral for **x-rays** will be made to visualize the location of spinal problems.

Step 5

If your case requires immediate attention, first day Chiropractic care will be administered.

Step 6

You will be advised as to a time you can return for your "First Adjustment Visit" where your doctor will briefly outline your initial care recommendations and one of our Chiropractic Health Assistants will review a few of our office policies with you.

Step 7

You will also be advised as to a time you can return for a "**Doctor's Report**" done by one of our doctors. During the Doctor's Report we will give you, your family and friends the opportunity to learn what you can do to help us return you to health more <u>quickly</u> and <u>cost effectively</u>, and what one needs to do to stay <u>healthy</u>. Our records show that those patients who respond most rapidly to care are those who have learned to help themselves.

The doctor will go over your examination results, provide you with copies of your tests and answer any questions you may have. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step 8

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.



Doctor
Info Entered
Referred By

Category
Signatures
Thank You

Personal Details	MS	MSI Health Card Number:		
Name:	Address:			
City:	 Province:	Postal Code:		
Home Phone:				
Cell Phone:		Current Pronouns:		
		Business Phone:		
Type of Work:				
		Number of Children:		
		:Relationship:		
Current Health Condition				
Current Complaint(s):				
Other doctors seen for this condition?				
	Resul	ts:		
When did this condition begin?	Has th	ne condition occurred before? Yes No		
s the condition: ☐ WBC Claim ☐ Auto	-related □ Home Inju	ıry 🗌 Fall 🔲 Other:		
Date of Accident:	Time of A	ccident:		
		☐ Bending ☐ Lifting ☐ Walking ☐ Dampness ☐ Other:		
What relieves your condition?		☐ Heat ☐ Massage ☐ Medication		
s it getting: Worse Co	onstant	oes □ Better		
Character of Pain: ☐ Sharp ☐ Du	ıll ☐ Ache	☐ Pins & Needles ☐ Numb ☐ Burning		
☐ Constant ☐ Int	ermittent			
Please describe how it feels when this pr	oblem is at its worse:			
Place an X on the grade to indicate the s	overity of your pain:			
-		7 8 9 10 worst		
LEAST 1 2 3 Compare this problem at its worst and a t	4 5 6			
	-	i. How does this problem interfere with.		
		se over the next 5 years? ☐ Yes ☐ No		
		Relaxers ☐ Blood Pressure Medicine		
5 ,				
		consulting up for?		
סכ you suller from any other condition th	an the one you are now	consulting us for?		
		t to correcting this problem:		
Have you had X-rays taken in the last six	months? Yes 1	No If yes, where?		

Motor Vehicle Accidents Work Injuries Hospitalization (other than above): Previous Chiropractic Care: None Doctor's Name: Approximate Date of Last Visit: Previous Chiropractic Care: None Approximate Date of Last Visit: Parally Health History Name of Family Physician: 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 had a spinal check-up? No Yes If yes, where and when? Please of chiropractic care. Have your children ever had a spinal check-up? No Yes If yes, where and when? Please of chiropractic care. Please of	Past Health History		
Previous: Childhood Traumas Sports Injuries Work Injurie	Major Surgery/Operations: □	Appendectomy ☐ Tonsillectomy ☐ Ga	ll Bladder □ Hernia □ Back Surgery
Previous: Childhood Traumas Sports Injuries Work Injurie		Broken Bones ☐ Other:	
Motor Vehicle Accidents Work Injuries Hospitalization (other than above): Previous Chiropractic Care: None Doctor's Name: Approximate Date of Last Visit: Previous Chiropractic Care: None Approximate Date of Last Visit: Parally Health History Name of Family Physician: 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 had a spinal check-up? No Yes If yes, where and when? Please of chiropractic care. Have your children ever had a spinal check-up? No Yes If yes, where and when? Please of chiropractic care. Please of			
Previous Chiropractic Care: None Doctor's Name: Approximate Date of Last Visit:	Motor Vehicle Accid		
Previous Chiropractic Care:			
Approximate Date of Last Visit: Family Health History	riospitalization (other than above	o)	
Name of Family Physician:	Previous Chiropractic Care:	☐ None ☐ Doctor's Name:	
Name of Family Physician:			
Name of Family Physician:			
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 had a spinal check-up? 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 chiropractic care. Check any of the following you have had in the past six months: Nervous System General Gastro - Intestinal Nervous Fatique Poor/Excessive Appetite Nervous Paralysis Loss of Sleep Prequent Nausea Dizziness Pever Vomiting Porgetfulness Headaches Diarrhea Confusion / Depression Constipation Fainting C-V-R Hemorrhoids Convulsions Chest Pain Liver Problems Cold / Tingling Extremities Short Breath Gall Bladder Problems Stress Blood Pressure Problems Male / Female Low Back Pain Lung Problems Male / Female Gas/Bloating After Meals Varicose Veins Menstrual Irregularity Heartburn Stroke Vaginal Pain / Infections Neck Pain Vision Problems Black/Bloody Stool EENT Prostate / Sexual Dysfunction Arm Pain Vision Problems Genito-Urinary Bladder Trouble Malking Problems Discolored Urine Difficult Chewing/Clicking Jaw Hearing Difficulty Discolored Urine			
Parents: Siblings:	Name of Family Physician:		
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Siblings: 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? Have your children ever had a spinal check-up? No Yes If yes, where and when?	·	· · · · · · · · · · · · · · · · · · ·	
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Numbness	Nervous System	General	Gastro - Intestinal
□ Paralysis □ Loss of Sleep □ Frequent Nausea □ Dizziness □ Fever □ Vomiting □ Forgetfulness □ Headaches □ Diarrhea □ Confusion / Depression □ Constipation □ Fainting C-V-R □ Hemorrhoids □ Convulsions □ Chest Pain □ Liver Problems □ Cold / Tingling Extremities □ Short Breath □ Gall Bladder Problems □ Stress □ Blood Pressure Problems □ Weight Trouble □ Irregular Heartbeat □ Abdominal Cramps Musculo-Skeletal □ Heart Problems □ Low Back Pain □ Lung Problems/Congestion Male / Female □ Gas/Bloating After Meals □ Varicose Veins □ Menstrual Irregularity □ Pain Between Shoulders □ Ankle Swelling □ Menstrual Cramping □ Heartburn □ Stroke □ Vaginal Pain / Infections □ Neck Pain □ Breast Pain / Lumps □ Black/Bloody Stool EENT □ Prostate / Sexual Dysfunction □ Arm Pain □ Vision Problems Genito-Urinary □ Joint Pain/Stiffness □ Sore Throat □ Bladder Trouble □ Walking Problems □ Painful / Excessive Urination<	☐ Nervous	☐ Fatique	☐ Poor/Excessive Appetite
□ Dizziness □ Fever □ Vomiting □ Forgetfulness □ Headaches □ Diarrhea □ Confusion / Depression □ Constipation □ Fainting C-V-R □ Hemorrhoids □ Convulsions □ Chest Pain □ Liver Problems □ Cold / Tingling Extremities □ Short Breath □ Gall Bladder Problems □ Stress □ Blood Pressure Problems □ Weight Trouble □ Low Back Pain □ Lung Problems/Congestion Male / Female □ Gas/Bloating After Meals □ Varicose Veins □ Menstrual Irregularity □ Pain Between Shoulders □ Ankle Swelling □ Menstrual Cramping □ Heartburn □ Stroke □ Vaginal Pain / Infections □ Neck Pain □ Breast Pain / Lumps □ Black/Bloody Stool EENT □ Prostate /Sexual Dysfunction □ Arm Pain □ Vision Problems Genito-Urinary □ Joint Pain/Stiffness □ Sore Throat □ Bladder Trouble □ Walking Problems □ Ear Aches □ Painful / Excessive Urination □ Difficult Chewing/Clicking Jaw □ Hearing Difficulty □ Discolored Urine	☐ Numbness	☐ Allergies	☐ Excessive Thirst
□ Forgetfulness □ Headaches □ Diarrhea □ Confusion / Depression □ Constipation □ Fainting C-V-R □ Hemorrhoids □ Convulsions □ Chest Pain □ Liver Problems □ Cold / Tingling Extremities □ Short Breath □ Gall Bladder Problems □ Stress □ Blood Pressure Problems □ Weight Trouble □ Irregular Heartbeat □ Abdominal Cramps Musculo-Skeletal □ Heart Problems □ Low Back Pain □ Lung Problems/Congestion Male / Female □ Gas/Bloating After Meals □ Varicose Veins □ Menstrual Irregularity □ Pain Between Shoulders □ Ankle Swelling □ Menstrual Cramping □ Heartburn □ Stroke □ Vaginal Pain / Infections □ Breast Pain / Lumps □ Breast Pain / Lumps □ Black/Bloody Stool EENT □ Prostate /Sexual Dysfunction □ Arm Pain □ Vision Problems Genito-Urinary □ Joint Pain/Stiffness □ Sore Throat □ Bladder Trouble □ Walking Problems □ Ear Aches □ Painful / Excessive Urination □ Difficult Chewing/Clicking Jaw □ Hearring Difficulty □ Discolored Urine <td>☐ Paralysis</td> <td>☐ Loss of Sleep</td> <td>☐ Frequent Nausea</td>	☐ Paralysis	☐ Loss of Sleep	☐ Frequent Nausea
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☐ Difficult Chewing/Clicking Jaw ☐ Hearing Difficulty ☐ Discolored Urine			
	_		
L. General Stiffness L. Stiffed Nose	☐ General Stiffness	☐ Stuffed Nose	in Discolored Office

Females Only	Check any of the following	Lifestyle Stress Levels		
When was your last period?	diseases you have had:	\square High		
	☐ Pneumonia	☐ Moderate		
	\square Mumps	☐ Very Little		
Are you pregnant?				
\square Yes \square No \square Not Sure	☐ Rheumatic Fever			
	☐ Small Pox			
Intake (Note amt/week)	☐ Shingles	 		
□ Coffee	☐ Pleurisy			
□ Tea	☐ Polio			
☐ Alcohol	☐ Chicken Pox			
☐ Cigarettes	☐ Arthritis	1 /1/ : N/ / /N/ L		
☐ Cannabis	☐ Tuberculosis			
	☐ Diabetes			
Satisfaction with Diet	☐ Epilepsy			
☐ Highly Satisfied	☐ Whooping Cough			
☐ Dissatisfied	☐ Cancer			
☐ Highly Dissatisfied	☐ Mental Disorder			
	☐ Anemia	I \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	☐ Heart Disease	I)3{{ }		
Do you have a regular	☐ Lumbago			
exercise program?	☐ Measles			
☐ Yes	\Box Thyroid	Please outline on the diagram the area of		
□ No	☐ Eczema	your discomfort and any radiation of pain.		
Why Chiropractic Care?				
in having the cause of the problem as malfunctioning in their bodies brought to the the three phases of care. Your doctor will	well as the symptoms corrected and reli- ne highest state of health possible with chiro	a condition (Relief or Acute Care). Others are interested eved (Corrective Care). Still others want whatever is practic care (Preventative or Wellness Care). These are mending your schedule of care. However, the prepared t from Chiropractic is always up to you.		
Please check the type of care desired so	that we may be guided by your wishes wl	henever possible:		
 □ Preventative or Wellness Care □ Corrective or Rehabilitative Care □ Relief or Acute Care □ Check here if you want the doctor to 	select the type of care appropriate for your co	ondition.		
Please Read Carefully:				
I understand and agree that health and accunderstand that the Doctor's Office will preany amount authorized to be paid directly agree that all services rendered me are continuous.	pare any necessary reports and forms to as to the Doctor's Office will be credited to my harged directly to me and that I am person	between an insurance carrier and myself. Furthermore, I sist me in making collection from the insurance and that account on receipt. However, I clearly understand and ally responsible for payment. I also understand that if I vices rendered me will be immediately due and payable.		

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy 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 doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments 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 there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. 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 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.

Signature:	Date:	
•	_	