ST MARGARET'S BAY
Chiropractic Centre
BODY • FAMILY • LIFE

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 **"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

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

5798 St. Margaret's Bay Road, Head of St. Margaret's Bay, Nova Scotia, B3Z 2E4 Tel: 902-826-1088
Fax 826-1089 Website - www.stmargaretsbaychiro.com Email - info@stmargaretsbaychiro.com

ST MARGARET'S BAY
Chiropractic Centre
BODY • FAMILY • LIFE

☐ *Doctor* *Category*
☐ *Info Entered* *Signatures*
☐ **Referred By** **Thank You**

MSI HEALTH CARD NUMBER: _____

Personal Details

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Birthdate: _____ Age: ____ ·Sex: M
Cell Phone: _____ Gender at Birth: _____ Current _____ Pronouns _____
Business/Employer: _____ Business Phone: _____ Type of Work: _____
_____ E-Mail Address: _____
Number of Children: _____ Emergency Contact: _____ Phone Number: _____
Relationship: _____ Who may we thank for referring you to this office?

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 the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ WBC Claim ☐ 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
Please describe how it feels when this problem is at its worse: _____

Place an X on the grade to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem 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 this problem make you feel? _____
If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other: _____
Do you suffer from any other condition than the one you are now consulting us for? _____
On a scale of 1 to 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

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: _____
Approximate Date of Last Visit:

Family 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? _____

_____

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

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

Musculo-Skeletal

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

General

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

C-V-R

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

EENT

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

Gastro - Intestinal

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

Male / Female

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

Genito-Urinary

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Females Only

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake (Note amt/week)

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Cannabis

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

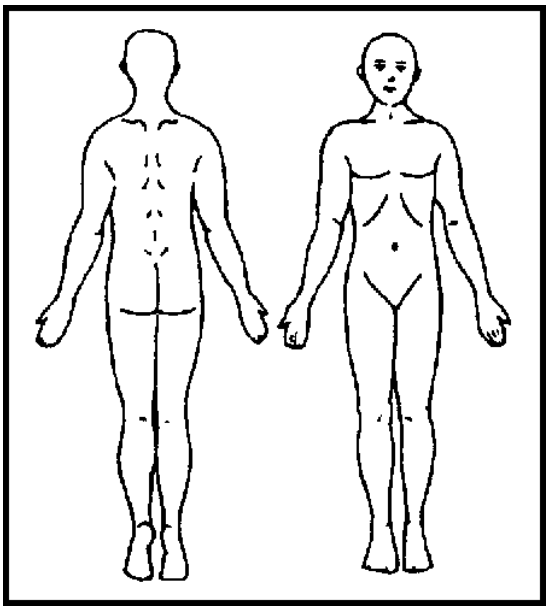
- ☐ Yes
- ☐ No

Check any of the following diseases you have had:

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

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little



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

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief or Acute Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative or Wellness Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever 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 condition.

Please Read Carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services 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. Disc Injury or Aggravation: 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 in the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

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 pert 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.

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.

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: _____
Signature of patient (or legal guardian)

_____ Date: _____
Signature of Chiropractor