Confidential Patient Health Record

DATE	
HEALTH NO:	

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ❑ M ❑ F

Business/Employer: _____ Type of Work: _____

Business Phone: _____

Name of Partner (if applicable): _____

Partner's Business Phone: _____ Type of Work: _____

Name and Number of Emergency Contact: _____ Relationship: _____

How did you hear about this office? _____

IS THIS VISIT: ❑ AN I.C.B.C. CLAIM ❑ A WORK RELATED INJURY

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

_____

_____

Other Doctors seen for this condition: ❑ Yes ❑ No Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occured before? ❑ Yes ❑ No

Are you currently taking any medication? ❑ Yes ❑ No Please list: _____

_____

Do you wear orthodics or a heel lift? ❑ Yes ❑ No

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

Do you have extended Health Coverage? ❑ Yes ❑ No

PAST HEALTH HISTORY

Please check and describe: _____

Major surgery/operations: ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia

❑ Back Surgery ❑ Broken Bones ❑ Other: _____

Major accident or falls: _____

_____

Hospitalization (other than above): _____

Previous Chiropractic care: ❑ None ❑ Doctor's name & approximate date of last visit: _____

_____

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

Have you been tested HIV positive? ☐ Yes ☐ No

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

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

GASTRO-INTESTINAL CODE

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

MALE/FEMALE CODE

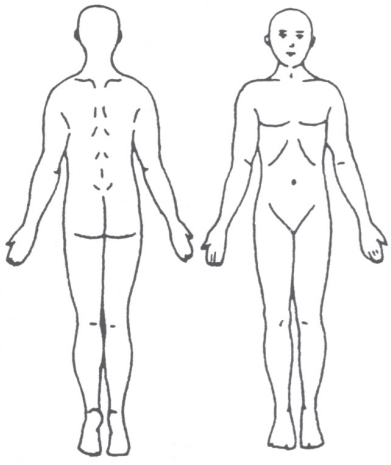
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

EENT CODE

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

GENITO-URINARY CODE

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



Please outline on the diagram above, the area of your discomfort.

NERVOUS SYSTEM CODE

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

C-V-R CODE

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

GENERAL CODE

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

FEMALES ONLY

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

FAMILY HISTORY – The following members have a same or similar problem as I do:

☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Spouse ☐ Child

CHIROPRACTIC ANALYSIS – DO NOT WRITE BELOW THIS LINE

DIAGNOSIS: Patient Accepted? ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature

THINGS YOU NEED TO KNOW

- We do not believe in charging for missed appointments, so if you need to reschedule please give as much notice as possible. However, short notice is better than none.
- When you are referring your family, friends and co-workers to this office for check ups, care or consultations we will make every effort to accommodate their personal schedules.
- Booking your appointments in advance will help to ensure you get the times you want and punctuality, of course, is appreciated.
- Payment is expected when services are rendered unless prior arrangements have been made.

ADULT FEE SCHEDULE

Initial Visit:	$60.00
Subsequent Visits:	$40.00

V2 OR R2 STATUS FEES

Initial Visit:	$30.00
Subsequent Visits:	$15.00

CHILDREN'S FEE SCHEDULE

Children 12 years old and older pay regular patient fees.

For children between 0-5 years old, whose parents are patients, there is no charge.

Initial Visit: 0-12 yrs	$35.00
Subsequent Visits:	$20.00

If you or your children have V2 or R2 status, please advise us if you have seen any of the following professionals in the current calendar year:

- ☐ Massage Therapist (RMT)
- ☐ Podiatrist
- ☐ Physiotherapist
- ☐ Naturopath

IF YOU HAVE ANY QUESTIONS REGARDING FEES, PLEASE ASK.

604.738.2205

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM - L

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:**_____

(please print) **(please print)**