[Broddick] Chiropractic and Acupuncture
86 STANLEY ST, AYR, ON, N0B 1E0
PHONE: 519.394.0099
FAX: 519.394.0172

REGISTRATION & HISTORY

Date _____

PATIENT INFORMATION

Name: _____

Address: _____

City Prov. Postal Code

Phone: _____

Work / Cell: _____

Email: _____

Sex: □M □F Age: D.O.B. _____

□ Single □ Commonlaw □ Mar □ Separated □ Divorc □ Widow

Occupation: _____

Employer: _____

Spouse's Name: _____

Occupation: _____

How did you hear about the clinic?

Have you ever been to a chiropractor? □No □Yes (please list)

HEALTH INSURANCE

Extended □ Yes □ No

Please note: we will provide receipts for each visit for you to submit to your insurer - check your coverage and requirements

ACCIDENT INFORMATION

Is condition due to an accident? Y / N Date: _____

Type of Accident □ Auto □Work □ Home □Other

To Whom have you made a report of your accident?

□ Auto Insurance □ Employer □Worker Comp. □ Other

Auto Accident

Name of Auto Ins.: _____

Address: _____

Adjuster's Name: _____

Phone/Fax: _____

Policy No. Date of Loss:

WSIB

Adjudicator Name _____

Claim #: _____

SIN #:

PURPOSE OF CONSULTING WITH OFFICE (PLEASE CHECK ALL THAT APPLY)

□ I am in pain or suffer from a health condition and would like to be examined and treated to get some relief

□ I have no current pain/condition but I am interested in being examined and treated for preventative maintenance

□ I am interested in being assessed for orthotics and/or compression socks/stockings/garments

PATIENT CONDITION

Current symptom(s): _____

When did it start/what caused it? _____

Is this condition getting progressively worse? □Yes □No □Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain □ Sharp □ Dull □ Numbness □ Aching □ Shooting □ Burning
□Tingling □ Throbbing □ Stiffness □ Swelling □ Other _____

Is it constantly there or off and on? _____

Is there anything that relieves it? _____

Activities / Movements that are painful/difficult: □Job/Work □ School □ Sleep □ Daily Routine □ Sports/Recreation
□Sit □ Stand □ Walk □ Bend □ Other _

What treatments have you already received for your condition? □ Medical □ Physio □ None □ Chiro □ Massage □ Other

SYMPTOMS PAST & PRESENT

Please **CIRCLE** any conditions/symptoms that are **PRESENT now**
Please **CHECK** those conditions/symptoms that were there in the **PAST**

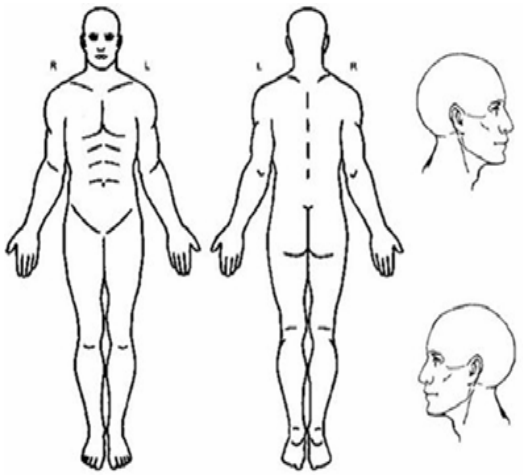
General Symptoms	**Muscles & Joints**	**Eyes, Ear, Nose, Throat**	**Cardiovascular**
Loss of consciousness	Neck pain	Blurred vision	Heart/blood disease
Depression	Upper back pain	Asthma	High blood pressure
Headache	Low back pain	Deafness	Low blood pressure
Fevers	Wrist pain	Ear aches	High cholesterol
Sweats	Hand pain	Ringing/Buzzing in ears	Bleeding disorder
Convulsions	Hip pain	Enlarged glands	Pain over the heart
Loss of Sleep	Knee pain	Hyperthyroidism	Stroke/Heart attack
Numbness, pain, tingling	Foot pain	Hypothyroidism	Swelling of the ankles
Loss of weight	Shoulder pain	**Respiratory**	Poor circulation
Fainting	Arthritis	Difficulty breathing	**Gastrointestinal**
Tremors	Bursitis	Chronic cough	Poor appetite
Allergy	Swollen Joints	Spitting up phlegm/blood	Constipation Diarrhea
Chills	**Skin**	Chest pain	Colitis/irritable bowel
Convulsions	Rashes, itching	**Genitourinary (women)**	Gallbladder trouble
Dizziness	Bruise easily	Excessive menstrual flow	**Other**
Vomiting	Hives or allergy	Painful menstruation	Cancer
Nausea	Varicose veins	Irregular menstrual cycle	Fibromyalgia
		Menstrual cramps	Diabetes

HABITS

□ Smoking	Packs/Day
□ Alcohol	Drinks/Week
□ Caffeine Drinks	Cups/Day
□ High Stress	Reason

EXERCISE	WORK ACTIVITY
□ None	□ Sitting
□ Moderate	□ Standing
□ Heavy	□ Light Labor
	□ Heavy Labor

Draw your injury / pain



INJURIES & SURGERIES YOU HAVE HAD

	Description	Date
Car accidents		
Head Injuries		
Fractures		
Dislocations		
Surgeries		

DO YOU HAVE ANY KIDS? (LIST HOW MANY AND THEIR AGES)

MEDICATIONS (prescription and over the counter)

ALLERGIES

VITAMINS/HERBS/MINERALS/SUPPLEMENTS

Do you suffer from any other health conditions or do you have any other health concerns?

□ No □ Yes (please list)

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

Doctors of Chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with treatment. In particular, you should note:

* While rare, some patients have experienced rib fractures or muscle and ligament strains following spinal adjustments
* There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause strokes, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote
* There have been reported cases of disc injuries following cervical and lumbar spinal adjustments, although no scientific study has ever demonstrated such injuries may be caused by spinal adjustments or chiropractic treatments
* There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.
* Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than those associated with many medical treatments, medications, and procedures given for the same symptoms.
* I acknowledge I have discussed, or have had the opportunity to discuss, with the 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.

Patient's Name_____

Are you pregnant? _____

Patient's Signature_____

Date Signed _____

Witness (chiropractor)_____

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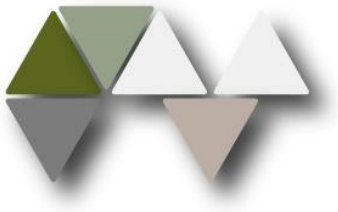

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncture provider named below. I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, cupping, and electrical stimulation. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax. Infection is another possible risk, although the acupuncture provider below uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

I will notify the acupuncture provider who is caring for me if I am or become pregnant. I do not expect the acupuncture provider to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncture provider to exercise judgment during the course of treatment which the acupuncture provider thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name_____

Are you pregnant? _____

Patient's Signature_____

Date Signed _____

Witness (chiropractor)_____

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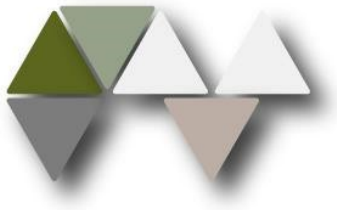

Appointment Policies

For your convenience, we take the time to schedule your appointments appropriately so that you may receive the best one on one treatment without interruptions. We kindly ask that you provide us with a minimum 24 hours notice if you are not able to make your scheduled appointment to avoid a cancellation charge of $45.00. At that time, we will gladly reschedule your appointment to better suit your schedule. We try our very best to respect your appointment time and all we ask is that you respect ours.

Financial Policies

Pricing: Initial chiropractic or acupuncture visit=$85 (kids 10yrs and under $50). Subsequent chiropractic or acupuncture visit=$45 (kids 10yrs and under $30). Orthotics=$450. Compression socks/ stockings=$90-$180. Cervical pillows=$85. Biofreeze=$20. All treatment must be paid at the time of service. Deposits are required for orthotics/compression garment orders. It is your responsibility to confirm coverage if you have extended health insurance and to submit receipts to your insurer. We accept Visa, MasterCard, Interac, Cash and Personal Cheque (with a major credit card on file). *NSF cheques will be subject to a $75.00 charge to cover costs accrued from our financial institution.

Authorization for Release of/Obtaining Medical Information

By signing below I hereby authorize [Broddick] Chiropractic and Acupuncture to exchange all and any relevant information related to my personal health care file (when required) with my medical doctor(s) and other health care professionals that have managed me currently and in the past. In addition, I authorize [Broddick] Chiropractic and Acupuncture to exchange all and any relevant information related to my personal health care file with (when required) hospitals, law firm, WSIB, employers and insurance companies. I also authorize the health care providers/staff at [Broddick] Chiropractic to exchange records and information contained within my file when necessary to better serve you.

By signing below I am indicating that I have read and understand the office policies/authorization outlined above. I understand that as a patient of [Broddick] Chiropractic and Acupuncture, I am expected to comply with such policies at all times.

_____ _____

Print Patient Name Patient Signature

_____

Date

Witness (Signature) _____