[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**

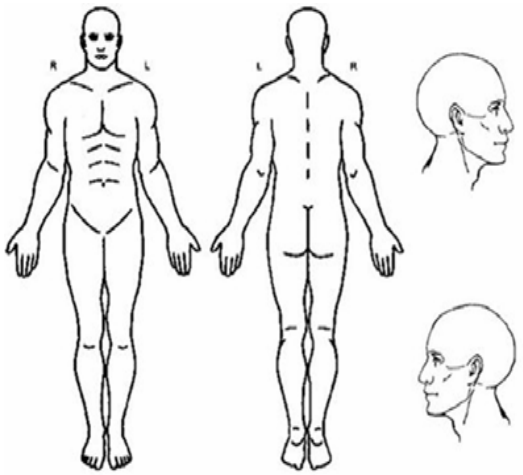
General Symptoms	**Muscles & Joints**	**Eyes, Ear, Nose, Throat**	**Cardiovascular**
Loss of consciousness	Neck pain	Blurred vision	Heart/blood disease
Depression	Upper back pain	Asthma	High blood pressure
Headache	Low back pain	Deafness	Low blood pressure
Fevers	Wrist pain	Ear aches	High cholesterol
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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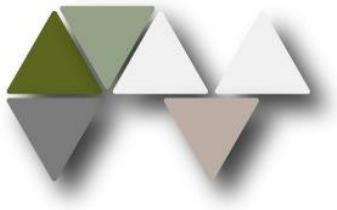

Appointment Policies

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) _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
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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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

INFORMED CONSENT FOR ACUPUNCTURE CARE

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

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants
- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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 read this form and 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 acupuncture treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date