



PATIENT ENTRANCE FORM

Date _____ Circle: Male Female
Name _____ Birth Date (dd/mm/yy) _____ Age _____
Address _____ Apt # _____ City _____ Province _____
Postal Code _____ Home # _____ Cell # _____
Work # _____ E-MAIL _____
Occupation _____ Employer _____
Name of Emergency Contact _____ Contact # _____
How were you referred to our office ? (include NAME) _____

Family Dr and # _____ Last physical exam date _____
Surgeries or illnesses (include dates) _____
Fractures or past injuries (includes dates) _____
Medications _____
X-RAYS taken: Yes No Date _____ Results _____
Have you been treated for any health condition by a physician/chiropractor in the last year? Yes No
If yes, describe _____

Extended Health Care Company _____
Do you need any help retaining information about your health insurance coverage? Yes No

AUTHORIZATION AND RELEASE

I authorize the doctor to release all information necessary to communicate with personal healthcare providers.

PAYMENT POLICY

I understand that payment is due at the time professional services are rendered to me. I understand that I am responsible for all costs of treatment care, regardless of insurance coverage.

MISSED APPOINTMENT POLICY

There is a \$10 fee for missed appointments without any notification. Our office does not charge for cancelled appointments, but requests **12 hours notice** to reschedule an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

Patient's Signature _____ Date _____
Guardian's Signature Authorizing Care _____ Date _____

Name: _____

HEALTH HISTORY

Please indicate whether you have experienced any of the following: **N = NOW** **P = PAST**

Fever / Chills _____	Allergies _____	Shoulder/Elbow/Hand Pain _____
Headaches _____	Arthritis _____	Hip/Knee/Foot Pain _____
Migraines _____	Loss of Balance _____	Numbness in Fingers _____
Stiff Neck _____	Loss of Taste _____	Numbness in Toes _____
Neck Pain _____	Loss of Smell _____	Shortness of Breath _____
Back Pain _____	Difficulty Urinating _____	Chest Pain / Tightness _____
Tension _____	Unusual Bowel Patterns _____	High Blood Pressure _____
Nervousness _____	Hands Cold _____	Indigestion Problems _____
Irritability _____	Feet Cold _____	Weight Loss / Gain _____
Dizziness _____	Sinus Problems _____	Diabetes _____
Fainting _____	Ringing in Ears _____	Joint Pain / Swelling _____
Weakness _____	Depression _____	Fatigue _____
Muscle Spasms _____	Sleeping Problems _____	Loss of Memory _____

Women: Menstrual Difficulties _____
 Are you pregnant? _____
 Date of Last Period _____
 Date of Last Pap _____
 Date of Last Mammogram _____

SOCIAL HISTORY

Please indicate whether you engage in these: **OFTEN = √** **SOMETIMES = S** **NEVER = X**

_____ Caffeine Intake	_____ Social Pressures
_____ Tobacco Use	_____ Financial Pressures
_____ Alcohol Use	_____ High Stress Activity
_____ Drug Use	_____ Other (please specify)
_____ Exercise	_____

FAMILY HISTORY

Please indicate diseases and conditions that are current health problems of a family member.

Condition _____	Family Member _____	Age _____
Condition _____	Family Member _____	Age _____
Condition _____	Family Member _____	Age _____

PAIN DRAWING & SCALE

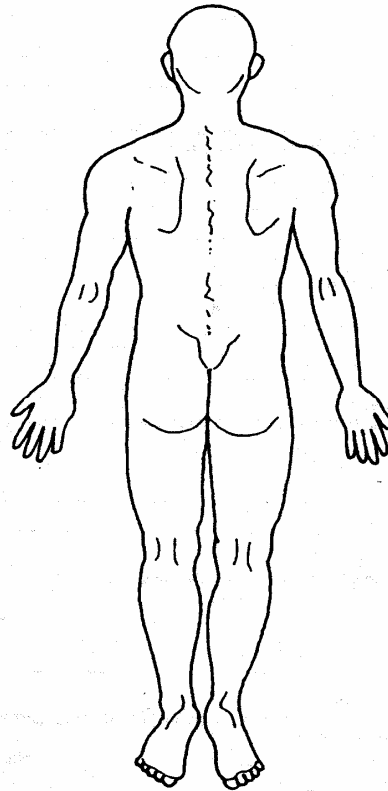
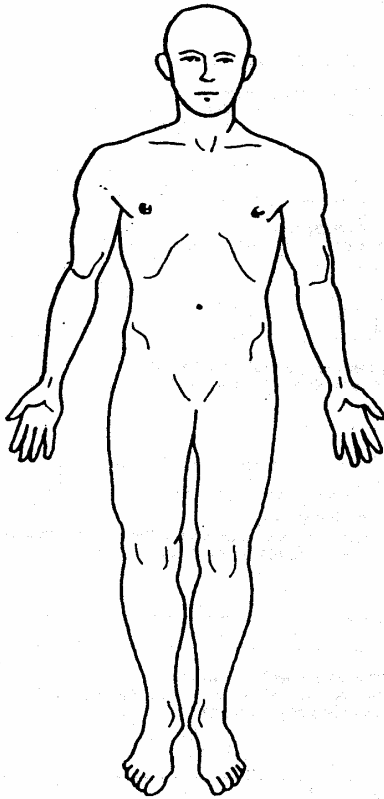
TELL US WHERE YOU HURT

Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>
Burning x x x x x

Numbness =====
Stabbing //////////////

Pins & Needles o o o o o
Throbbing ~~~~~~



TELL US HOW MUCH YOU HURT

On a scale of 0 to 10, please mark with an "X" the level of your pain today. 0 indicates no pain while 10 indicates the worst pain you have ever experienced.

0 1 2 3 4 5 6 7 8 9 10

Informed Consent to Chiropractic &/OR Acupuncture Treatment

CHIROPRACTIC

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

- a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.
- b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.
- c) There have been rare reported cases of disc injuries following cervical or 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 adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other 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.

ACUPUNCTURE

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles.

I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

PLEASE READ BEFORE SIGNING

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

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

I consent to the chiropractic &/or acupuncture treatments offered or recommended to me by my chiropractor (including spinal adjustment).

Date

(Print Name)

(Sign – patient, or guardian)

Witness