

CONFIDENTIAL PATIENT INFORMATION SHEET

NP # _____

Please complete FULLY and accurately.

OFFICE USE ONLY

PERSONAL HISTORY

Name: _____ Date: _____
Date of birth: _____ Age: _____ Sex: Male or Female (please circle)
Address: _____ City: _____ Postal code: _____
Tel: Home _____ Business or Cell (circle) _____
Where do you wish to be contacted? (check) [] Home [] Business [] Cell
Occupation: _____ Marital status: _____ # of children _____
Family Dr (Name & Tel.): _____
Emerg contact (Name, Tel. & Relationship): _____
E-Mail address: _____

How were you referred to this clinic?

[] Massage Therapist [] Friend/family (specify) _____
[] Naturopathic Doctor [] Health/injury talk _____
[] Advertising/pamphlet/website [] Other (please specify) _____

Is this a Workplace Safety & Insurance Board injury (WSIB)? [] N [] Y

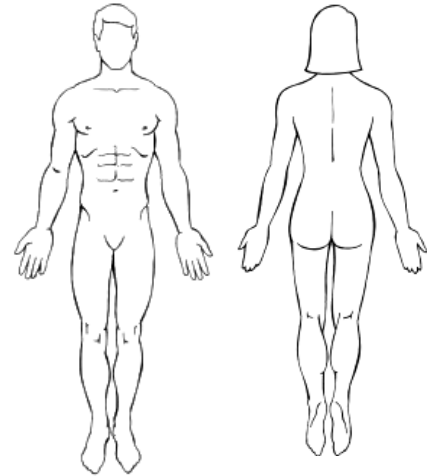
Are your injuries related to a Motor Vehicle case? [] N [] Y

CURRENT HEALTH HISTORY

Current complaint(s) – in order of importance to you

1) _____
2) _____
3) _____

On the drawings to the right mark all painful areas with an X



Describe the pain:

- [] Sharp & stabbing [] Burning
[] Pins & needles [] Dull, ache
[] Numb [] Stiff & tight

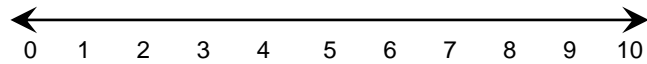
How long have you had this injury? _____

Have you had it before? [] N [] Y

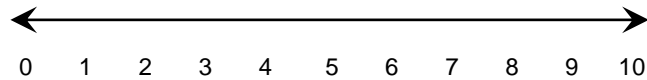
Previous Chiropractic care? [] N [] Y

Reason for treatment: _____

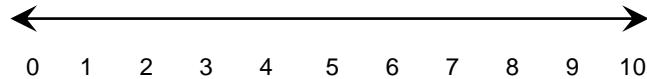
Circle your level of Pain/discomfort (0 = no pain, 10 = worst pain)



Circle your general level of Stress (0 = low stress, 10 = high stress)



Circle your level of Commitment to correcting the problem (0 = low level, 10 = high level)



Current exercise routine (type of activity, frequency, duration): _____

List any medications, supplements (vitamins, etc) that you are currently taking: _____

- Do you wear Orthotics? N Y - If YES, how long have you had them? _____
- Are you a smoker? N Y - If YES, _____ cigarettes/day for _____ years
- Do you drink? N Y - If YES, _____ glasses per week
- Personal satisfaction with diet? Highly satisfied Satisfied Dissatisfied
- Sleep: Hours per night _____ Height: _____ Weight: _____
- FEMALES ONLY: Are you pregnant? N Y

FAMILY HEALTH HISTORY

Have you or anyone in your family had the following (specify whom):

- Heart disease _____ High blood pressure _____
- Cancer _____ Diabetes _____
- Stroke _____ Other diseases _____

PAST HEALTH HISTORY

List any previous **Surgeries** and the year(s) they occurred

_____ Year _____ Year _____

List any previous **Fractures** and the year(s) they occurred

_____ Year _____ Year _____

List any previous **Accident / traumas** and the year(s) they occurred

_____ Year _____ Year _____

GENERAL HEALTH INFORMATION

Please check the symptoms you have experienced in the **past 6 months**

HEAD AND NECK

- Headache Neck pain Hearing problems Ringing in the ears
- Sinusitis Vertigo/ Dizziness Eye problems Vision problems
- Nose problems TMJ (jaw pain) Sore throat Voice changes

CHEST, LUNG, HEART, AND SKIN

- Chest pain Palpitations (heart) Blood pressure problems Allergies
- Insomnia Night sweats Lung problems Shortness of breath
- Asthma Skin problems Restlessness, irritability

DIGESTIVE SYSTEM AND MISCELLANEOUS

- Nausea, vomiting Heartburn Poor appetite Loss of taste
- Bloating Diarrhea Constipation Abdominal pain
- Gas, rumbling Hemorrhoids Frequent weight change Bruising easily

LIVER AND GALL BLADDER

- Liver problems Sweaty palms Sweats easily Irritated easily
- Brittle nails Bitter taste in mouth Muscle cramps Anxiety
- Slow digestion Tension headaches Stiff joints and muscles Restlessness

KIDNEY, URINARY TRACT, ENDOCRINE SYSTEM AND VARIOUS

- Kidney stones Urinary bladder problems Kidney problems Prostatitis
- Frequent urination Urinary tract infections Incontinence Feeling cold/hot
- Feeling low energy Low back pain Joint pain Weak or sore knees

GYNECOLOGICAL SYSTEM (WOMEN ONLY)

- Painful periods Heavy periods Irregular periods Long periods
- Absent periods Hot flashes Endometriosis Painful intercourse
- Fertility problems Pre-menstrual syndrome Miscarriages, abortions Breast problems

OUR FEES

Type of appointment	Adults	Seniors (65+), Students	Children (<5yrs)
Initial visit	\$85	\$65	\$55
Subsequent chiropractic visit	\$35	\$32	\$27
Subsequent acupuncture visit	\$45	\$45	
Subsequent visit with chiro/acu	\$53	\$50	
Orthotics with Gait Analysis	Regular - \$400; shoes - \$500		

****PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.**

Payment can be made by cash, cheque, debit, VISA/MC. If you cannot attend an appointment, please give **24 HOURS NOTICE** so that another patient may receive care during that time. I have read the above and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____

INFORMED CONSENT

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

While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation.

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 sometime causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical adjustment is extremely remote.

There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or Chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated Chiropractic treatment to be effective for spinal pain, headaches and other similar symptoms. Chiropractic care may contribute to your overall well-being. The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with other treatments, medications and procedures given for the same symptoms.

I acknowledge, I have discussed or have had the opportunity to discuss, with Dr. McDonald the nature and purpose of Chiropractic treatment in general and my treatment in particular as well as the contents of the consent. I consent to the Chiropractic treatment offered or recommended to me by Dr. McDonald, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Date _____

_____ **Print patient/guardian name**

_____ **Signature of patient/guardian**

_____ **Print name of witness**

_____ **Signature of witness**

ACUPUNCTURE TREATMENT

I understand and am informed that in the practice of Acupuncture there are risks to treatment. These include but are not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, possible perforation of organs and stuck or bent needles. I have been advised that only pre-sterilized single use needles will be used.

Date _____

_____ **Print patient/guardian name**

_____ **Signature of patient/guardian**