CONFIDENTIAL PATIENT INFORMATION

Chiropractic

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____
(YYYY/MM/DD)

Employer: _____ Occupation: _____

Alberta Health Care #: _____ Marital Status: _____

Family Physician: _____

Emergency Contact: _____ Phone: _____

How would you like to receive your appointment reminders: __Email ___Text*

**CELL PHONE PROVIDER (required for TEXT reminder)* __ Bell __Telus __Fido __ Koodo __Virgin __Rogers __PC Mobile

Have you ever been under Chiropractic care? __ Yes __ No

If yes, with who and when? _____

How did you hear about our office?_____ If referred, who can we thank?_____

Is this a motor vehicle accident case? __Yes __No Date of accident: _____

Is this a Workers' Compensation Board case? __Yes __No Date of accident: _____

Major complaints/Symptoms: _____

When did this problem begin? _____

Do you experience any of the following?

__Numbness __ Tingling __ Weakness __ Bowel or Bladder changes

Please indicate in which area of the body you experience these sensations: _____

Which treatments/therapies has you tried? __ Over the counter medications __ Heat __ Ice

Do you suffer from headaches? __No __Yes: How Often_____

Do you suffer from any foot or knee issues? __No __Yes

Females: Are you pregnant? __No __Yes: How many weeks_____

Which other Southcentre Health and Wellness services are you interested in?

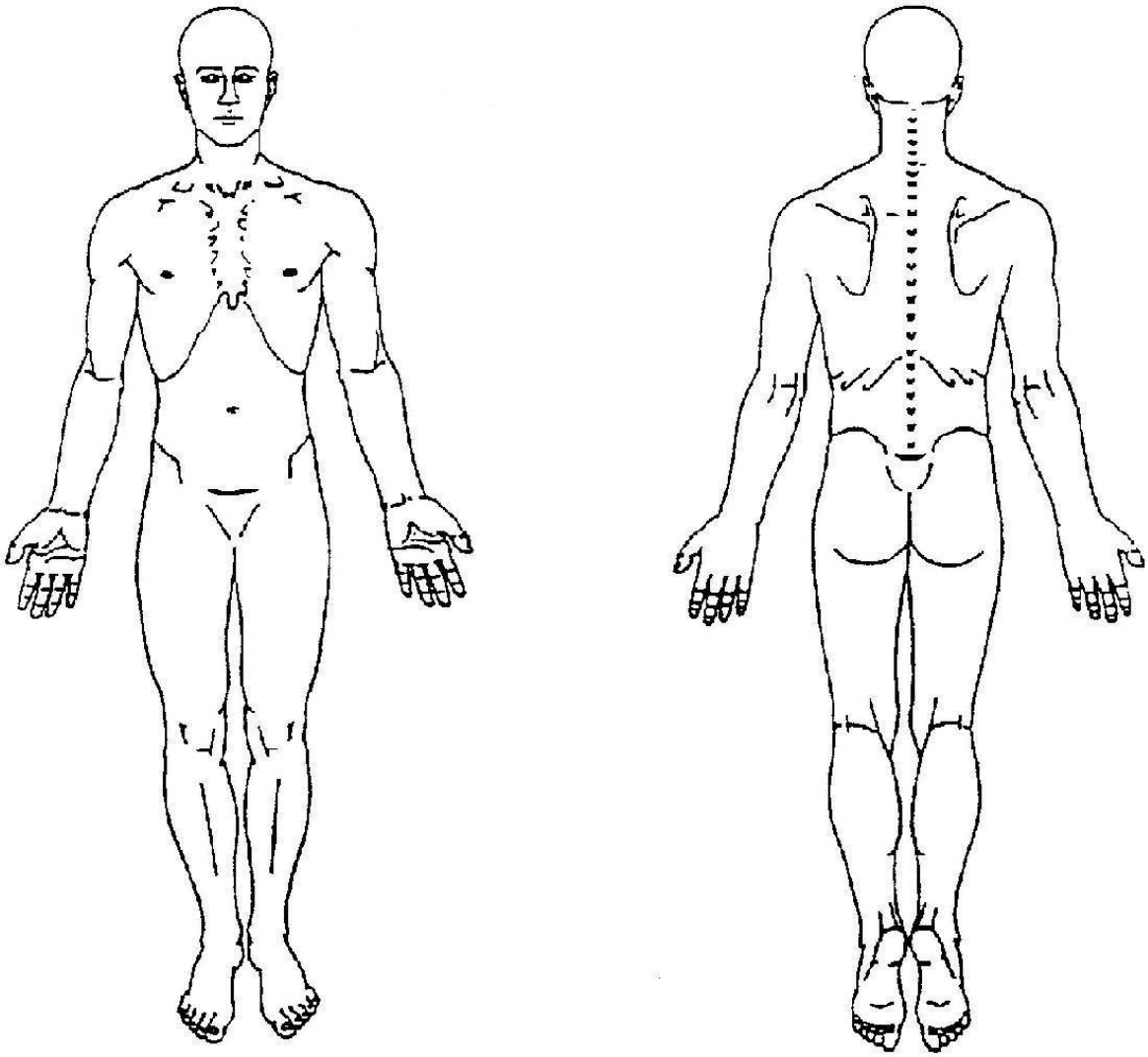
__ Massage Therapy __ Acupuncture __ Custom Foot Orthotics __ Nutrition

SOUTHCENTRE
HEALTH & WELLNESS

PAIN DRAWING

On the drawing below, please indicate where you are experiencing pain by drawing the letter abbreviation(s) on the diagrams that most accurately reflect the type of discomfort that you are experiencing.

NUMBNESS – **N** TINGLING – **T** DULL PAIN – **D**
SHARP PAIN – **P** BURNING – **B** STIFFNESS - **S**



PATIENT HISTORY

If you have ever had a listed condition in the past, please check in the **Past** column. If you are presently troubled by a particular condition, check it in the **Present** column. The information you provide concerning past and present conditions and diseases assists your doctor in a more thorough understanding of your state of health.

Past	Present		Past	Present	
□	□	Neck pain	□	□	Frequent urination
□	□	Shoulder pain	□	□	Abdominal pain
□	□	Pain in upper arm or elbow	□	□	Constipation/irregular bowel habits
□	□	Hand pain	□	□	Difficulty swallowing
□	□	Wrist pain	□	□	Heartburn/indigestion
□	□	Upper back pain	□	□	Dermatitis/eczema/rash
□	□	Low back pain	□	□	Depression
□	□	Pain in upper leg or hip	□	□	Aortic aneurysm
□	□	Pain in lower leg or knee	□	□	High blood pressure
□	□	Pain in ankle or foot	□	□	Angina
□	□	Jaw pain	□	□	Heart attack
□	□	Swelling/stiffness of joints	□	□	Stroke
□	□	Fainting	□	□	Asthma
□	□	Visual disturbances	□	□	Cancer
□	□	Convulsions	□	□	Tumor
□	□	Dizziness	□	□	Prostate problems
□	□	Headaches/migraines	□	□	Blood disorder
□	□	Muscular incoordination	□	□	Emphysema (chronic lung disorder)
□	□	Tinnitus (ringing in the ears)	□	□	Arthritis
□	□	Rapid heart beat	□	□	Rheumatoid arthritis
□	□	Chest pains	□	□	Diabetes
□	□	Loss of appetite	□	□	Epilepsy
□	□	Anorexia	□	□	Ulcer
□	□	Abnormal weight gain / loss	□	□	Liver/gall bladder problems
□	□	Excessive thirst	□	□	Kidney stones
□	□	Chronic cough	□	□	Hepatitis
□	□	Chronic sinusitis	□	□	Bladder infection
□	□	General fatigue	□	□	Kidney disorders
□	□	Irregular menstrual flow	□	□	Colitis
□	□	Breast soreness/lumps	□	□	Irritable colon
□	□	Endometriosis	□	□	HIV / AIDS
□	□	PMS	□	□	Systemic Lupus
					Other:
□	□	Loss of bladder control	□	□	_____
□	□	Painful urination			
□	□	Pregnancy			
□	□	Birth control pills			
□	□	Hormone/estrogen replacement			
□	□	Tobacco			
□	□	Alcohol			
□	□	Drug or alcohol dependence			
□	□	Coffee/tea/soft drinks: cups per day _____			
□	□	Medications: _____			
□	□	Hospitalizations: _____			

If a relative (by blood) has had any of the following, please mark the appropriate box:

□ Cancer □ Epilepsy □ Rheumatoid arthritis
□ Diabetes □ Lupus □ High blood pressure
□ Chronic back problems □ Heart Problems
□ Chronic headaches/migraines □ Lung problems
□ Other conditions:

_____

INFORMED CONSENT FOR 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 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 awhile.

  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.
- **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 an 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 with 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.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT CONTINUED

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. DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

_____
Name (please print)

_____ _____
Signature of Patient (or legal guardian) DATE

_____ _____
Signature of Chiropractor DATE

OFFICE FINANCIAL POLICY

Cancellation Policy

The time you have booked for your appointment is valuable. If you will not be able to attend a scheduled appointment, it is your responsibility to call the office with at least 24 hours notice to reschedule it. Failure to do so will result in 100% of the appointment cost being charged to you.

Direct Billing

Insurance Company_____ Name of Plan Holder_____

ID #_____ Policy#_____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

Date: _____

_____ _____
Patient Signature (or Legal Guardian) Witness Signature

_____ _____
Patient Name (please print) Witness Name (please print)

Appointment Reminders

Please understand that it is your responsibility to keep booked appointments. As a courtesy we offer email/text message reminders. If for whatever reason you do not get a confirmation by text or email, it is still your responsibility to be on time for this appointment.