Associate Chiropractic Centre

Welcome to Our Office!

Outline of Procedures for New Patients

Step 1

All patients are requested to fill out a confidential ***Patient Health Record*** on the following pages.

Step 2

You will have your first ***Consultation*** with the doctor to discuss your health problems.

Step 3

You will receive an ***Examination*** to determine what type of treatment, if any, is appropriate for your condition.

Step 4

The doctor will communicate their findings, examination results, and diagnosis. The recommended treatment will be explained to you, including the benefits and risks of the treatment. You will be asked to sign an ***Informed Consent*** form before any treatment begins.

Step 5

You will be advised of your options concerning financial arrangements and insurance coverage, as appropriate.

To allow us to better serve you, please complete *ALL* questions on the following pages.

Thank you!

Personal History

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Birthdate: _____ Age: _____ Sex: ☐M ☐F

Occupation: _____ Business Phone: _____

Email: _____ # of Children: _____ Emergency Contact: _____

Emergency Contact Phone Number: _____ and Relationship: _____

Who told you about this office? ☐ Family Doctor:_____ ☐ Other: _____

Will this be a Worker's Compensation Board Claim? ☐Yes ☐No

Current Health Condition

Your current complaint(s): _____

When did this condition begin? _____ Has it occurred before? ☐Yes ☐No

If this condition has occurred before, when? _____

What caused it? ☐Work Injury ☐Car Accident ☐Home Injury ☐Fall ☐I don't know

If you know, describe what caused it: _____

If there was an accident, please give the: a) date: _____ b) time: _____

Have you seen other doctors for this condition? ☐No ☐Yes → Dr. _____

Type of Treatment: _____ Results of Treatment: _____

What aggravates your condition? ☐Sitting ☐Standing ☐Bending ☐ Lifting ☐Walking ☐ Lying Down ☐Cold ☐Exercise ☐Other: _____

What relieves your condition? ☐Rest ☐Ice ☐Massage ☐Medication ☐Heat ☐Chiropractic ☐Exercise ☐Other: _____

Is the problem: ☐Constant ☐Comes/Goes ☐Getting Worse ☐ Getting Better

How does it feel: ☐Sharp ☐Dull ☐Ache ☐Pins & Needles ☐Numb ☐Burning

Other description on how it feels: _____

Place circle the grade below to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? _____ Have you missed work? ☐Yes ☐No

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or sports? _____

At its worst, how **OLD** does this problem make you feel? _____

If you don't get the problem corrected, do you think it will get worse over the next 3 months? ☐Yes ☐No

Drugs you take now: ☐Painkillers ☐Muscle Relaxers ☐Anti-Inflammatory ☐Blood Pressure Medicine
☐Insulin ☐Anti-depressants ☐Cholesterol ☐Blood Thinners
☐Osteoarthritis ☐Rheumatoid Arthritis ☐Heart Pills ☐Osteoporosis
☐Others: _____

Do you suffer from any other condition than the one you are now consulting us for? _____

Have you had X-rays, CT scans or an MRI, of your problem area, taken before? ☐Yes ☐No

If yes, what test and of what area? _____ When? _____

Past Health History

Major Surgery/Operations: ☐Appendectomy ☐Tonsillectomy ☐Gall Bladder
☐Hernia ☐Back Surgery ☐Broken Bones
☐Other: _____

Previous: ☐ Childhood Traumas Date: _____ Injuries: _____
☐ Sports Injuries Date: _____ Injuries: _____
☐Motor Vehicle Accident Date: _____ Injuries: _____
☐ Work Injuries Date: _____ Injuries: _____

Hospitalizations (other than above): _____

Previous Chiropractic Care? ☐No ☐Yes → Doctor's Name: _____

Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician/Nurse Practitioner: _____

Please indicate any significant health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐No ☐Yes →Whom? _____

Females Only
When was your last period?
_____
Are you pregnant?
☐Yes ☐No ☐Not Sure

Dietary Intake
☐Coffee
☐Tea
☐Alcohol
☐Cigarettes
☐Cannabis

Satisfaction with Diet
☐Highly Satisfied
☐Satisfied
☐Dissatisfied
☐Highly Dissatisfied

Do you have a regular exercise program?
☐No
☐Yes
What?
_____

Lifestyle Stress Levels
☐High
☐Moderate
☐Low

Do you take any vitamins or supplements?
☐No
☐Yes
If yes, please list:
_____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care. Check any of the following that you have ***within the last year:***

Nervous System
☐Nervous
☐Paralysis
☐Dizziness
☐Vertigo
☐Forgetfulness
☐Depression
☐Fainting
☐Falling
☐Balance Disturbances
☐Convulsions
☐Tingling in hands/fingers
☐Tingling in feet/toes
☐Numbness/Tingling Elsewhere

Musculo-Skeletal
☐General Stiffness
☐Low Back Pain
☐Neck Pain
☐Pain between Shoulders
☐Headaches
☐Shoulder Pain
☐Arm Pain
☐Hip Pain
☐Knee Pain
☐Foot/Feet Pain
☐Joint Pain/Stiffness
☐Walking Problems
☐Difficulty Chewing
☐Wrist Pain

General
☐Fatigue
☐Allergies
☐Loss of Sleep
☐Fever
☐Significant Stress
☐Weight Trouble
☐Anemia

C-V-R
☐Chest Pain
☐Shortness of Breath
☐Lung Problems/Congestion
☐Pneumonia
☐Ankle Swelling

Male / Female
☐Menstrual Irregularity
☐Menstrual Cramping
☐Vaginal Pain / Infections
☐Breast Pain / Lumps
☐Prostate Problems
☐Sexual Dysfunction
☐Benign Prostatic Hypertrophy

Genito-Urinary
☐Bladder Trouble
☐Painful / Excessive Urination
☐Discolored Urine

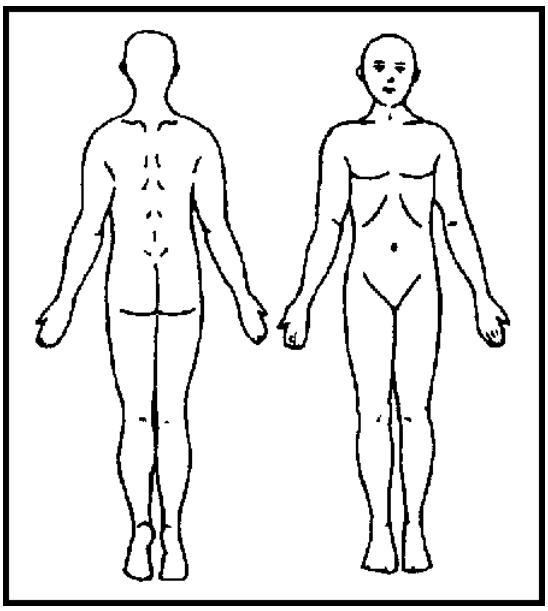
EENT
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Ear Aches/Infections
☐Hearing Difficulty
☐Stuffed Nose

Gastro-Intestinal
☐Poor Appetite
☐Excessive Thirst
☐Frequent Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Liver Problems
☐Gall Bladder Problems
☐Abdominal Cramps
☐Gas/Bloating after Meals
☐Heartburn
☐Black/Bloody Stool

Check the following diseases that you have ***ever had:***

☐Cancer
☐Mumps
☐Influenza
☐Rheumatic Fever
☐Small Pox
☐Polio
☐Chicken Pox
☐Arthritis
☐Tuberculosis
☐Diabetes Type 1
☐Diabetes Type 2
☐Whooping Cough
☐Mental Disorder
☐Heart Disease
☐Lupus
☐Measles
☐Thyroid
☐Eczema
☐Blood Pressure Problems
☐Irregular Heartbeat
☐Heart Problems
☐Heart Attack
☐Stroke
☐Congestive Heart Failure
☐Varicose Veins
☐Kidney Stones
☐Pregnancy/Birth
☐Colitis
☐Epilepsy
☐Other: _____
☐Other: _____
☐Other: _____

Notes:
_____



Please draw on the diagram the areas of your pain/discomfort and anywhere your pain travels

Please add any other comments about your pain/discomfort:

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative/Wellness Care). These are three phases of care. Your doctor will weigh your needs and desires when giving you recommendations. However, the prepared recommendation incorporates all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐Preventative Care "Wellness Care" – This involves Life Enhancement and Preventative strategies.
- ☐Corrective Care "Fix" – This involves Removing The Cause and Remodeling Soft Tissue.
- ☐Relief Care "Patch" – This is Band-Aid care only.
- ☐Check here if you want the doctor to select the type of care appropriate for your condition.

Fee Schedule

	Adults	**Student/Child**
New Patients:	85.00	75.00
Re-Examinations:	65.00	55.00
Progress Examinations:	55.00	45.00
Treatments:	45.00	37.00
Laser:	45.00	45.00

Methods of Payment
Cash, Cheque, Debit/Interac, Visa, MasterCard, Direct Billing and WCB
Payment is due when services are rendered

If You Have Insurance Coverage for Chiropractic Care,
Please check this box: ☐

For patients with extended health insurance that covers chiropractic care, our office will direct bill your health insurance plan when we are able to do so. Patients will be responsible for any balance not covered by their insurance plan.

If you have a Work-Related Injury and are covered by the Worker's Compensation Board,
Please check this box: ☐

Chiropractic care can be covered by the Worker's Compensation Board of Nova Scotia. Please advise staff prior to your consultation & examination if you have a work-related injury. Worker's Compensation will be billed directly when you have an accepted and approved claim, and there will be no costs to the patient. A referral from a medical doctor is not necessary. If you have any questions, please ask the doctor's assistants, or the doctor.

IMPORTANT!

Please read each statement and check the boxes below to indicate you agree:

☐ I have completed this questionnaire to the best of my knowledge.

☐ I consent to the collection of this information by the doctors and the administrative staff of this clinic.

☐ I am giving my consent to be examined by the clinic Doctor of Chiropractic and the doctor's assistants; I understand that the examination will be based upon my health history, consultation, and my current and past symptoms; I understand that an examination is necessary in order for the doctor to reach a diagnosis and/or clinical impression as to the cause of my pain/discomfort/dysfunction.

Print Patient Name
(or Legal Guardian) :_____ X _____
(Print Name) (Signature)

Today's Date: _____

THANK YOU!

ASSOCIATE CHIROPRACTIC CENTRE