Kingswood Chiropractic Health Centre

PERSONAL INFORMATION: Please read and complete both sides

Name____

Address ______________________________________

____

____

Phone: Residence (___)___________________ Business (___)_____________________

Cellular (___)___________________

Date of Birth: (dd/mm/yy)_________________ age:_____ gender: M F

Name of Parent/Guardian if patient is under 16: ____

Family Physician:_______________________________

Address: ______________________________________ Phone: (___)________________

____

Have you had x-rays taken for this complaint? Y N

Is this a work-related injury? Y N If yes, date of accident:_____________________

Is this a motor vehicle accident? Y N If yes, date of accident:_____________________

Have you ever seen another chiropractor? Y N

Did your medical doctor recommend that you seek chiropractic care? Y N

If necessary, may we contact your medical doctor? Y N

For privacy purposes, may we leave a message at home? Y N At work? Y N

Current Occupation: _______________

Please indicate how you wish to be addressed: Mr. Mrs. Ms Miss First Name other ________________

How did you hear about our office? ____

FEES:

Chiropractic care is considered "fee-for-service". All fees are due on the day of service.

Many extended health plans cover chiropractic. It will be your responsibility to review your policy and to submit the claim to be reimbursed by your health carrier.

Current Fees	Initial Consultation	Subsequent Visit
Adult	$ 85.00	$ 45.00
Child/Student	$ 60.00	$ 35.00

We will be happy to print a receipt to help with your claim.

I have read the above information and understand:

1. I am responsible for all fees. Workman's Compensation and Motor Vehicle Accident claims will be billed on my behalf, however if my claim is denied I am responsible for the bill.
2. All clinical records and materials pertaining to my care are the property of this clinic.
3. I am considered discharged on my own accord if multiple appointments are missed without notice.
4. I am to speak to the Doctor if I have questions or concerns or any unusual symptoms.
5. I will call the office to cancel/re-book my appointment should I find I have a conflict.

____ ____________________________

SIGNATURE DATE

Confidential Health Information:

Patient Name: ____________________
Date: ____________________

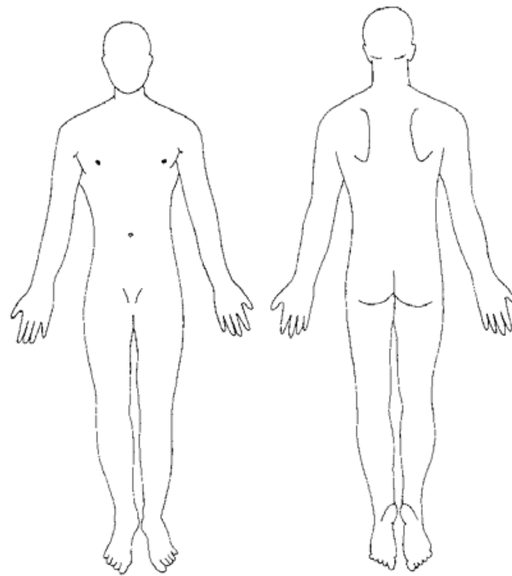
Have you ever been diagnosed with:

High Blood Pressure (Hypertension)	Y N
Hardening of the arteries	Y N
Diabetes	Y N
Heart Disease	Y N
Bone spurs on the neck	Y N
Whiplash	Y N
Double vision or Partial loss of vision	Y N
Slurred speech or difficulty swallowing	Y N
Dizziness	Y N
Loss of Consciousness	Y N
Numbness or Weakness in any part	Y N
Do you suffer from migraines?	Y N
Do you smoke?	Y N
Do you take oral contraceptives?	Y N
Do you take medication regularly?	Y N

If so, please list:______________
____
____
____

Please indicate on the figure below the area of your complaint and describe the discomfort using the symbols given. Please include all affected areas.

x x x = Burning ∗∗∗ = Aching
/ / / / = Stabbing o o o = Numbness
• • • = Pins and Needles



(Office-Use Only) Initial Patient History

Complaint:
Onset Acute / Chronic Recurrent / Sudden / Insidious / Traumatic
and Location

Prior occurrence

Prior treatment
X-rays y / n

Character Sharp / Dull / Stabbing / Burning / Aching / Constant

Intensity

Progression
over Day

Radiation

Aggravating

Relieving
Associated Sx: bladder/bowel?

Health Hx: Diabetes / Cancer / Heart Disease / Stroke

Family Hx: Diabetes / Cancer / Heart Disease / Stroke

Current Meds:

Sleep:
Exercise:
Diet:
Smoker?

Occupation:

Stress - Ability to Cope:

Secondary complaints:

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or 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 sprains or strains following spinal adjustments;

b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and 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 adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar 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.

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

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of __________, 20____.

______________________________	______________________________
Patient Signature Name: (please print)	Verification of Signature Name: (please print)