CONFIDENTIAL PATIENT INFORMATION

NAME:_____ **BIRTHDATE**:_____
(first) (middle) (last) (month/day/year)

ADDRESS:_____ **CITY**:_____ **POSTAL CODE**:_____

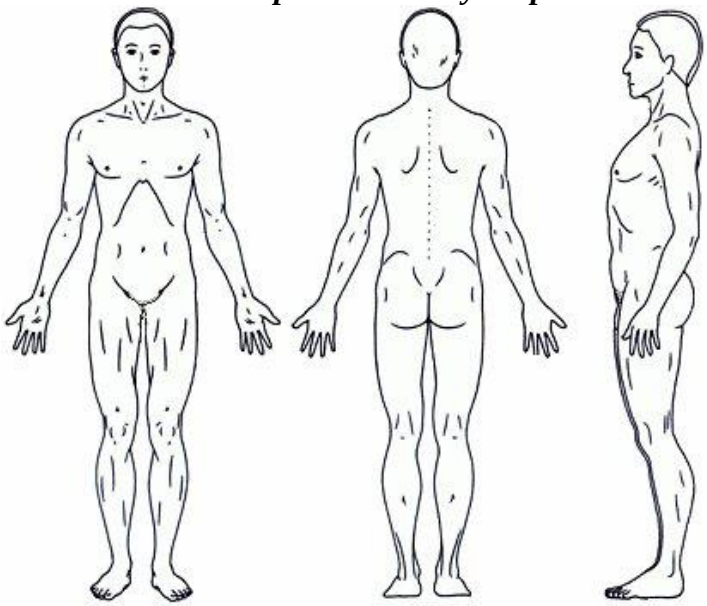
PHONE #:_____ **CARE CARD#**: _____

HEALTH PLAN PROVIDER(S):_____ **PLAN/GROUP/ID #:**_____

OCCUPATION: _____ **DOCTOR**: _____ **HEIGHT**:_____**WEIGHT:**_____

I consent to receive correspondence via email Initial [ ] **EMAIL:**_____

Please mark on the picture where your pain is:



Family History: (labels: ✓=*self* ***M****=mother,* ***F****=father,* ***S****=sibling*)

___High Chol./Blood Press. ___Cancer ___Diabetes
___Heart Disease/Attack ___Stroke ___Osteoarthritis
___Rheumatoid/Psoriasis/Gout) Other:

1) When did pain start; **what** were you doing?
_____
_____

2) Feels **better** when _____

3) Feels **worse** when _____

4) Sensation: sharp/dull/tingling/burning/numb/achy/ other:_____

5) Pain spreads along ARMS / LEGS / NONE

6) How bad is the pain**?**: _____/10

7) Frequency: RARELY, SOMETIMES, OFTEN, ALWAYS

8) Previous **x-rays/imaging** performed? YES / NO

9) Since it started, pain is BETTER/WORSE/SAME

10) Who else have you seen for this?_____
_____

11) Your Physical Activities:

MEDICATIONS (PRESCRIPTION & NON-PRESCRIPTION), VITAMINS/SUPPLEMENTS, ETC?
_____

PAST INJURIES, ACCIDENTS, BROKEN BONES, SURGERIES:_____
_____

MY SYMPTOMS:

Muscles and joints:	__Walking problems	__Bruising easily
__Lower back pain	__Numbness	__Chronic cough
__Pain amid shoulders	__Dizziness/Fainting	__Breathing trouble/Asthma
__Neck pain	__Headaches	__Weight change 10+lbs
__Arm problems	__Lightheadedness	__Heartburn
__Leg problems	__Confusion	__Constipation/Diarrhea
__Stiff/Painful joints	__Depression	__Hard to see/hear/smell
__Sore/Weak muscles	__Tiredness	Other:
__Joint swelling	__Difficulty sleeping	

To the best of my knowledge the above information I have provided is correct. I authorize the use of this form for confidential use by my Chiropractor.
Patient or Parent/Guardian Signature

_____

Date _____

OFFICE POLICY

Our Chiropractic treatment fees are in line with the recommended fee schedule for chiropractors in British Columbia. New patient $85; follow-up visits range from $55-$70; add'l fee for modalities/exercise therapy.

Initials ☐ **Private Insurance Billing:** Should you have a private insurance plan, we ***may be able to bill directly*** (based on your provider's services) to your insurer for you, which would help lower your out-of-pocket expenses for treatment. It is your responsibility to provide us your up-to-date insurance information and pay any fees not covered by your insurance.

Initials ☐ **Medical Services Plan (MSP, BC Care Card):** If you qualify for Premium Assistance, a **$23** subsidy ***may*** be deducted from your visit fees. This applies ***only*** if you have eligibility, ***and*** if you have not used up your **10** allowances for the calendar year. You will be responsible for the remainder of the fee at the time of your appointment.

Initials ☐ **Insurance Corporation of British Columbia (ICBC):** Please let the receptionist know if you have sustained a ***motor vehicle accident*** and have an ***active claim***. You may have access to chiropractic treatment through your ICBC claim. It is your responsibility to cover any fees for treatment which are not covered by ICBC.

Initials ☐ **WorkSafe BC:** Work injuries must be reported ***immediately*** to the doctor, regardless if you have filed/ intend to file an injury report at your workplace. Chiropractors are required to report any injuries which occur at the workplace to WorkSafeBC. A delay in you reporting costs your doctor a penalty fee which will be applied to your account and is non-reimbursable. ***WorkSafeBC policy requires that: you are responsible for any fees until WorkSafeBC has fully accepted a claim, at which time any fees can be reimbursed.***

Initials ☐ **Canadian Forces Members:** Referral from base medical services allots limited sessions for Chiropractic care. For additional sessions, the member must get approval/extension for treatment, or otherwise pay for further sessions.

Initials ☐ **Veterans (Department of Veterans Affairs):** Should you have coverage as indicated on your Veteran's Card, you must know what body part/body area your coverage is for. You will also need to provide us with your K#. We can help verify your coverage for treatment, which could include a minimum of 20 treatments per calendar year.

Initials ☐ **Missed Appointments, Cancellations, and Late Arrivals: An appointment time has been reserved for you. We require 24 hours notice for cancellations, so that your appointment time can be offered to another patient. Missed or cancelled appointments without proper notice are subject to the full appointment fee. Please call the clinic before you are late for your appointment; you will be accommodated if possible. Un-notified late-arrival of more than 5 minutes for your reserved appointment time may result in forfeiture; you are responsible for the full fee. *Repeated* abuse of aforementioned may result in the loss of future appointment privileges.**

- I have read the above office policy and understand my responsibilities as a patient.

Signature: _____ Date:_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
CONSENT TO 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 or 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 while.

  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 and 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 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.

Please sign this form with your chiropractor

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.

_____

Name (Please Print)

_____ Date: _____ 20____

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor