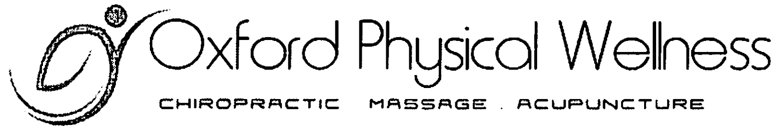



## CHIROPRACTIC PATIENT REGISTRATION

Please print clearly

Name: Gender: M / F

Address:

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

Phone (Home)

Phone (Cell)

Phone (Work)

Email:

Occupation:

Referred by:

Relationship to you:

Alberta Health Care #:

Work Extended Benefits ID:

Insurance Company:

Plan / Group #:

Cardholder Name:

<u>EMERGENCY CONTACT INFORMATION</u>

Name:

Phone Number:

Relationship:

Our clinic provides text/email reminders. To receive these services please provide either:

Cell phone service provider: Email address:

| | |
|---|---|
| Initial Assessment and Treatment | $85.00 |
| Subsequent Chiropractic Visit | $55.00 |

*Visit may include but is not limited to:*

*-Consultation* *-Adjustment* *-Joint work* *-Exercise-Muscle release therapy* *-Electro therapy*

*Please be aware you are responsible for the balance of the above fee schedule*

*Fees are due and payable at the time of service unless prior arrangements have been made*

*Date:* ______________________ *Patient Signature:* ______________________________

**Please check all answers and fill in the blanks where appropriate.**

Reason(s) for appointment: ______________________________

When did your condition begin? ______________________________

Have you ever had similar problems? ☐ Yes ☐ No

Have you had X-rays, MRI, or other tests for this condition? ☐ Yes ☐ No which tests, when? ______________

______________________________

Is this a work related injury? ☐ Yes ☐ No Has your employer been notified? ☐ Yes ☐ No

Is this a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No On what date did the accident occur? ______________

Can you perform daily home activities? ☐ Yes ☐ Yes, but only with help ☐ Not at all

Can you perform your daily work activities? ☐ All activities ☐ Only some activities ☐ Not at all

Describe your stress level ☐ None ☐ Mild ☐ Moderate ☐ High

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? ______________________________

Do you use Custom Foot Orthotics? ☐ Yes ☐ No If no, would you like to be fitted? ☐ Yes ☐ No

List all previous surgeries, illnesses, injuries (including MVA): ______________________________

______________________________

______________________________

Have you had previous chiropractic care? ☐ Yes ☐ No Dr. ______________ Date: ______________

Family doctor name: Dr. ______________________ Phone #: ______________________

List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.: __________

______________________________

______________________________

______________________________

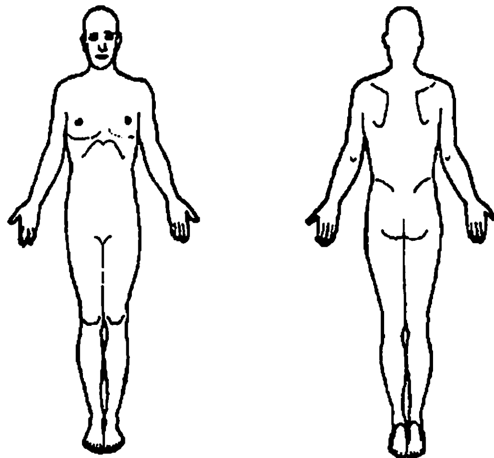
Date: ______________ Patient signature: ______________________________

## Health History Questionnaire

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---------------------------------------------------------------- Yes No
2. Hardening of the arteries (arteriosclerosis)------------------------------------ Yes No
3. Diabetes ---------------------------------------------------------------------------- Yes No
4. Tuberculosis ------------------------------------------------------------------------ Yes No
5. Cancer-------------------------------------------------------------------------------- Yes No
   Where? ______________________________________________
6. Heart or blood diseases-------------------------------------------------------------- Yes No
7. Bone spurs on the neck bones (cervical sprain) -------------------------------- Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)-------------------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ------------------ Yes No
10. Were you ever a smoker? ----------------------------------------------------------- Yes No
    From ____________________ to __________________
11. Do you take medication on a regular basis? ---------------------------------- Yes No
12. Visual disturbances (blurring, loss, double vision) ----------------------------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ------------------------------ Yes No
14. Slurred speech or other speech problems --------------------------------------- Yes No
15. Difficulty swallowing ---------------------------------------------------------------- Yes No
16. Dizziness ------------------------------------------------------------------------------ Yes No
17. Loss of consciousness, even momentary blackouts ---------------------------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body? ----------------- Yes No
19. Sudden collapse without loss of consciousness -------------------------------- Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain — Extreme pain

## Systems Review

**Circle** any conditions that are **presently** causing you a problem.
**Underline** those that have caused you problems in the **past**.

**GENERAL SYMPTOMS**

Fever
Sweats
Fainting
Sleep disturbance
Fatigue
Nervousness
Weight loss
Weight gain

**NEUROLOGICAL**

Visual disturbance
Dizziness
Fainting
Convulsions
Headache
Numbness
Neuralgia (nerve pain)
Poor coordination
Weakness

**EYES, EARS, NOSE, THROAT**

Eye pain
Double vision
Ringing in ears
Deafness
Nosebleeds
Trouble swallowing
Hoarseness
Sinus infection
Nasal drainage
Enlarged glands

**RESPIRATORY**

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Wheezing
Difficulty breathing
Asthma

**CARDIOVASCULAR**

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Hardening of arteries
Swollen ankles
Poor circulation
Palpitations
Cold hand or feet
Varicose veins

**MUSCLE & JOINT**

Neck pain
Low back pain
Arm pain
Shoulder pain
Leg pain
Knee pain
Foot pain
Pain/numbness down arms or legs
Pain between shoulders swollen joints
Spinal curvature
Arthritis
Fractures

**GENITOURINARY**

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Prostate trouble
Uncontrollable urine flow

**GASTROINTESTINAL**

Poor appetite
Difficult digestion
Heartburn
Ulcers
Nausea
Vomiting
Constipation
Diarrhea
Blood in stool
Gallbladder/jaundice
Colitis

**FOR WOMEN ONLY**

Painful menstruation
Hot flashes
Irregular cycle
Cramps or back pain
Vaginal discharge
Nipple discharge
Lumps in breast
Menopausal symptoms
Birth control pills
Miscarriages
Complications with pregnancy
Pregnant? Y / N Week?
Other:

Oxford Physical Wellness

# Electronic Transmission Authorization and Consent Form

**Message to the Plan member, Spouse and/or Dependent regarding Personal Information**
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

**Authorization and Consent**
I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
  Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

**Additional Consent Applicable to Plan Members Only**
I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted,
I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

**Date:** ____________________ **Patient Signature:** ____________________

**Print Name:** ____________________

# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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.**

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

____________________________ Date: ____________ 20____.
Name (Please Print)

____________________________ Date: ____________ 20____.
Signature of patient (or legal guardian)

____________________________ Date: ____________ 20____
Signature of Chiropractor