In Line Family Chiropractic
920 Yonge St S,
PO Box 1030
Walkerton, ON
N0G 2V0

519-881-3443
www.ilfc.ca

THE HEALTH RESTORATION SYSTEM

The **Health Restoration System** is a unique approach to achieving and maintaining optimal health .

Today in North America and the rest of the western world, the priority in health care is to help people after they are already sick. That is a backwards approach to health care, and it is why we are getting sicker and sicker. Recently a medical researcher stated it plainly, **"We are not living longer we are dying longer."** In other words, we have the capacity to keep people alive for longer and longer durations, but the majority of these people do not have a good quality of life. They cannot do most of the things that would allow them to live fulfilling lives.

Wouldn't it be great if we could work at staying healthy, instead of waiting to get sick? What if we could roll back the biological clock on the average person ? What if 50 really was the new 40? Or 60 was the new 50?

What if we could set up a system to allow you to do things at the age of 50, that you thought were impossible to do at the age of 40, or 30 for that matter?

That is exactly what the **Health Restoration System** is designed to do. We are here to help you live longer and healthier, not die longer!!

How does the **Health Restoration System** work?

1. DISCOVERY – HEALTH DANGERS

Unique questions will lead to new answers.

We will begin by looking at the current state of your health and wellness. In essence, how are you doing right now? We will also ask you some detailed questions about your **history** and your **family health history.**

It is important to understand that your current health problem started years ago and was multi-factorial in origin. The only exception would be an acute trauma like a car accident or severe sports injury. Even with acute traumas the extent of the injuries is most often dependent on your health before the accident. Your answers to the following questions offer up clues to what dangers your body is currently encountering and will give us a base line for comparison to future outcomes.

2. THE DISEASE CAUSATION ANALYSIS

We will explore which lifestyle factors are affecting your overall health and your ability to live fully alive. It is a well-known fact that 80% of the risk factors for the two most feared killers; heart disease and cancer, are lifestyle related. The same is true for the majority of chronic illnesses affecting patients today.

Lets get started in understanding your problem and finding a solution.

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DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

Name: _____

Address: _____ PO Box: _____

City: _____ Postal/Zip Code: _____

Phone #: _____ Cell or Home? Age: _____ Birth date: (M) _____ (D) _____ (Y) _____ Gender: M F

Workplace: _____ Office #: _____ Occupation: _____

Referred by: _____ ❍ Single ❍ Widowed ❍ Married (SPOUSE'S NAME): Common-law _____

# of Children: _____ and their ages: _____ Names: _____

Email: _____

PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year: _____ Injuries: _____
Year: _____ Injuries: _____
Year: _____ Injuries: _____

❍ High Speed Collisions >40km/h? ❍ Vehicles unrepairable?
❍ Whiplash injury? ❍ Un-belted accident?

SPORTS & RECREATION:

Sports injuries: _____
_____

Participation in High Impact Activities:

❍ Hockey ❍ Wrestling ❍ Basketball
❍ Running ❍ Mountain bike ❍ Climbing
❍ Football ❍ Gymnastics ❍ _____

FALLS

Falls from heights _____
Falls down stairs _____
Other falls _____
Broken bones _____
Childhood falls _____
_____
_____

Falls from:

❍ Trees ❍ Roof ❍ Play structure ❍ Bicycle

OCCUPATIONAL STRESSES

Occupation _____
Tasks _____
Work injuries _____
_____
Home injuries _____
My job requires:

❍ Heavy Lifting ❍ Awkward positions
❍ Repetitive stresses ❍ Sitting long periods

POSTURES & HABITS

❍ Sitting >6 hours/day ❍ Stomach sleeper
❍ Head forward posture

BIRTH TRAUMA was your delivery

❍ Difficult ❍ Forceps ❍ C-section
❍ Epidural ❍ Suction ❍ Resuscitation

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DISCOVERY - HEALTH DANGERS

WHAT IS YOUR PRESENT HEALTH CONCERN?

_____

_____

How long have you had this condition?

_____

Have you had a similar condition in the past?

_____

What activities aggravate your condition?

_____

What relieves your condition?

_____

Are you getting pain or numbness in your arms or legs?

_____

Is your condition getting progressively worse?

❍ Yes ❍ No ❍ It's constant ❍ It comes and goes

Pains are: ❍ Sharp ❍ Dull ❍ Burning

❍ Tightness ❍ Throbbing

Pain severity (mark on the line, 0 no pain; 10 most severe)

0 10

How is this condition interfering with your life?

❍ Work ❍ Daily Routine ❍ _____

Other doctors) who treated this condition:

_____

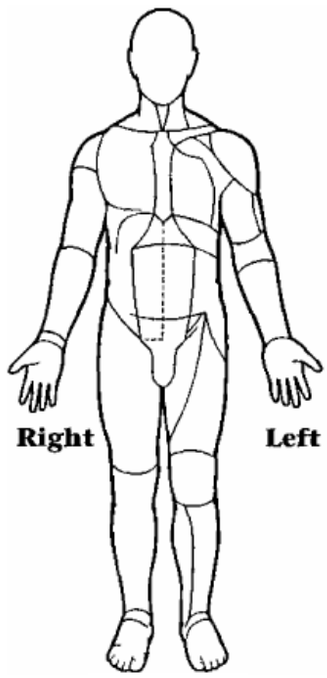
FAMILY HEALTH PROBLEMS?

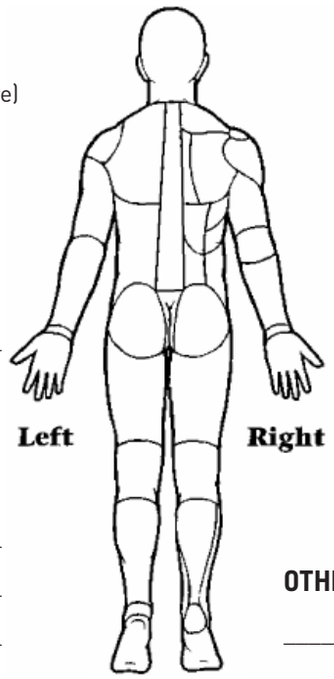
_____

_____

_____

_____





MARK WITH AN X ON THE DIAGRAM ANY PAST OR PRESENT PAIN OR PROBLEMS AND CHECK THE APPROPRIATE CIRCLE BELOW:

❍ Headaches ❍ Facial pain

❍ Vision problems ❍ Hearing problems

❍ Shoulder: Pain / Numbness / Tingling (circle)

❍ Arm: Pain / Numbness / Tingling (circle)

❍ Hand: Pain / Numbness / Tingling (circle)

❍ Hip: Pain / Numbness / Tingling (circle)

❍ Knee: Pain / Numbness / Tingling (circle)

❍ Foot: Pain / Numbness / Tingling (circle)

❍ Neck Pain

❍ Upper Back Pain

❍ Middle Back Pain

❍ Low Back Pain

❍ Sacroiliac Pain

OTHER HEALTH PROBLEMS?

_____

_____

_____

_____

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DISCOVERY - HEALTH DANGERS

PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED:

❍ Blurred /failing vision
❍ Deafness /ringing in ears
❍ Earaches
❍ Sore throat /tonsilitis
❍ Thyroid problems
❍ Sinus problems

Cardiovascular system

❍ Chest Pain
❍ Shortness of Breath
❍ Heart Medication
❍ High Blood Pressure Medication
❍ High Cholesterol Medication
❍ Swelling of Legs

Respiratory system

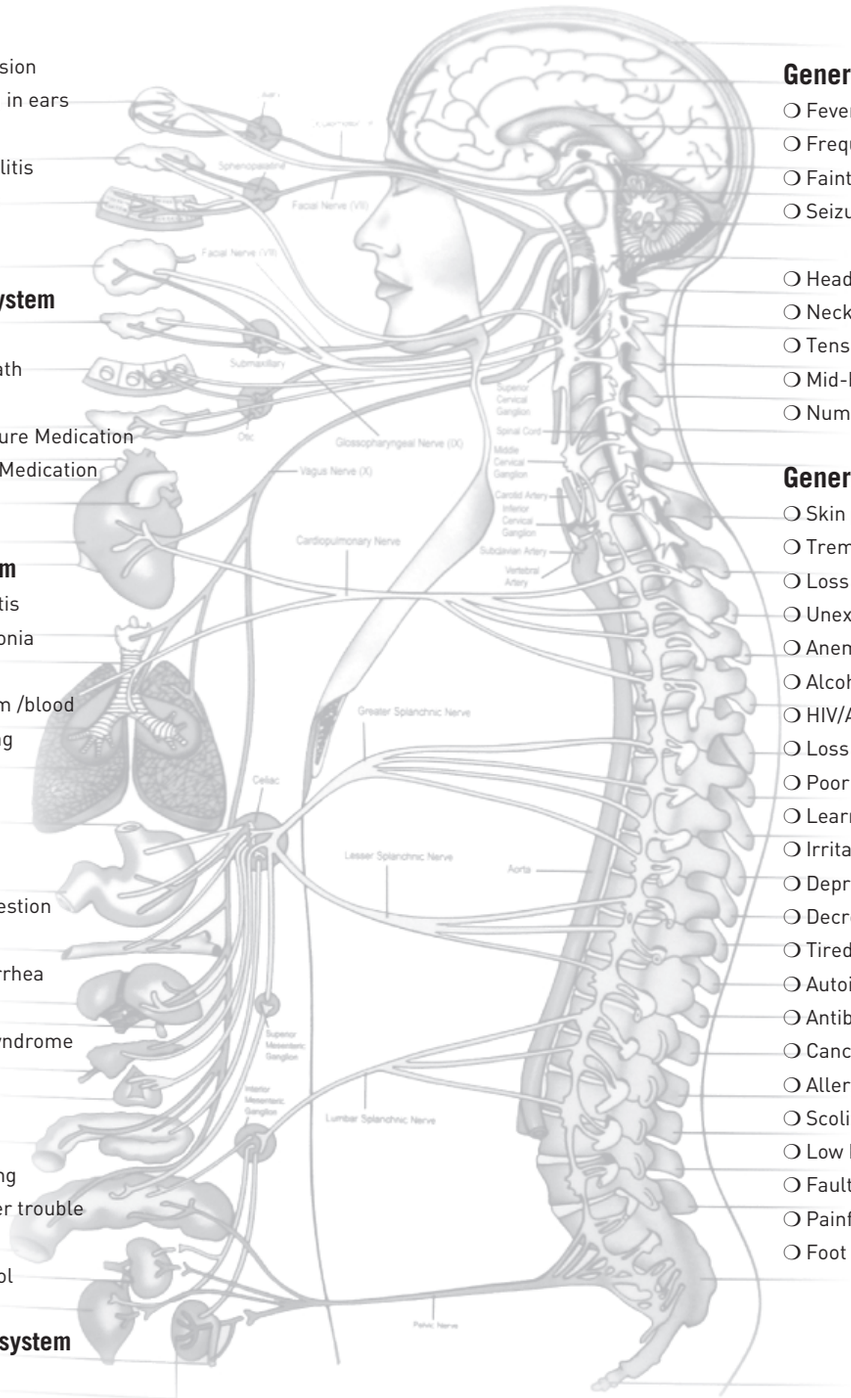
❍ Frequent bronchitis
❍ History of pneumonia
❍ Chronic cough
❍ Spitting up phlegm /blood
❍ Difficulty breathing
❍ Tuberculosis
❍ Pneumonia

Digestive system

❍ Heartburn / indigestion
❍ Stomach Cramps
❍ Constipation /diarrhea
❍ Food Allergy
❍ Irritable Bowel Syndrome
❍ Crohn's Disease
❍ Ulcers
❍ Belching /gas
❍ Nausea or vomiting
❍ Liver /gall bladder trouble
❍ Colon trouble
❍ Black /bloody stool

Musculoskeletal system

❍ Painful Joints
❍ Painful Muscles
❍ Tendinitis
❍ Bursitis
❍ Arthritis



General Symptoms

❍ Fever / chills / sweats
❍ Frequent colds
❍ Fainting / dizziness
❍ Seizures / convulsions

❍ Headaches /migraine
❍ Neck pain /stiffness
❍ Tension across shoulders, L R
❍ Mid-back pain /stiffness
❍ Numbness /tinglining: hands /arms

General Symptoms

❍ Skin problems
❍ Tremors
❍ Loss of balance
❍ Unexplained weight loss/gain
❍ Anemia
❍ Alcoholism
❍ HIV/AIDS
❍ Loss of sleep
❍ Poor memory /concentration
❍ Learning disability
❍ Irritable /nervous /tension
❍ Depression /emotional problems
❍ Decreased energy / fatigue
❍ Tired /lethargic
❍ Autoimmune Disease
❍ Antibiotic Use
❍ Cancer: _____
❍ Allergies / Asthma
❍ Scoliosis / spinal curvature
❍ Low back pain / stiffness
❍ Faulty posture
❍ Painful tailbone
❍ Foot trouble, L R

Females Only

❍ Painful menstruation
❍ Cramps or backaches
❍ Passed menopause
❍ Currently pregnant? ❍ Y ❍ N
❍ Excessive /irregular flow
❍ Abnormal discharge
❍ Miscarriages #_____
❍ Date of last menstrual period: _____

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DISCOVERY - HEALTH DANGERS

PERSONAL INFORMATION

How has your condition affected your quality of life? _____

_____

How has your condition affected you emotionally?_____

_____

How has your condition affected your family life and/or relationships? _____

_____

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? _____

_____

If you are a candidate for spinal reconstruction and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? _____

_____

What is your greatest motivation (other than pain) for seeking out a solution for your condition?
(Mobility, quality of life, family, participation in sports, etc.) _____

_____

_____

Do you believe that this condition can improve? _____

_____

DISEASE CAUSATION ANALYSIS

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EXERCISE

Do you participate in aerobic exercise at least 30 minutes per day?

❍ 0 days /week ❍ 1-2 days /week
❍ 3-4 days /week ❍ 5-7 days /week

Do you lift weights or do resistance training?

❍ P90x
❍ Crossfit
❍ Gym
❍ Other _____

What activities are you involved in that require balance?

❍ _____ ❍ None

How often do you stretch per week?

❍ 0 days /week ❍ 1-2 days /week
❍ 3-4 days /week ❍ 5-7 days /week

EMOTIONAL STRESS

Are you currently experiencing, or have you ever experienced significant stress in the following areas?

❍ Marriage _____
❍ Kids _____
❍ Finances _____
❍ Work _____
❍ Elderly Parents - Caregiver _____
❍ Recent Major Life Events (births, deaths) _____
_____

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

Parents / Siblings:_____
_____
Spouse / Partner:_____
_____
Children: _____
_____
_____

CHEMICAL STRESSES: NUTRITION

Do you feel that you make healthy food choices?

❍ Yes ❍ No ❍ Don't Know

Do you have a high intake of fruits and vegetables?

❍ Yes ❍ No ❍ Don't Know

Do you have a high intake of lean meat for protein?

❍ Yes ❍ No ❍ Don't Know

Are you at your ideal body weight?

❍ Yes ❍ No ❍ Don't Know

CHEMICAL STRESSES: TOXIC LOAD

Do you presently, or have in the past:

❍ Smoke? ❍ Carry excessive weight?
❍ Consume Alcohol? ❍ Take recreational drugs?

MEDICATIONS

For what condition(s)? _____
_____
_____
_____
_____
_____

SURGERIES

For what condition(s)? List (year performed) _____
_____
_____
_____
_____
_____
_____

Any other details that may assist the Doctor in understanding your lifestyle and health status: _____
_____
_____
_____
_____
_____

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Office Fee Schedule and Financial Policy

Service	Adult	Child/Student
Consultation	N/C	N/C
Initial Exam	$100	$50
X-ray Imaging	$25-$100	$25-$100
Adjustment	$50	$35
Initial ABC Treatment (New Patient)	$140	$140
Initial ABC Treatment (Existing Patient)	$110	$110
ABC Adjustment	$60	$60
Dynamic, Mid-Year, Year-End Exams	$30	$30
Progress exam	$25	$25
Low Volt Therapy	$2.50/minute	$2.50/minute
Initial Exam Laser/Low Volt Therapy	$50	$30
Laser Therapy	$40	$40
Ion Cleanse	$40	$40
Traction class	$20	$20
Traction units	$45-95	$45-95
Pro-Lordotic	$60	$60
In-House Traction	$35/15 minutes	
Orthotics: One Pair - $500.00	Two Pair - $775.00	
FHP Collar	$475	

January 1st of each year there will be an annual cost of living increase in the fees rounded to the closest dollar.

There is a $30.00 minimum fee for the reproduction and/or forwarding of a file to another practitioner.

Financial Policy and Chiropractic Adjustment Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Adjustment Plan in advance**. Adjustment Plans are designed to be the most cost-effective way to keep you and your family as healthy as possible, and include your Corrective care recommendations. Details of your plan will be discussed with you during your Report of Findings.

- **Benefits/Insurance:** If you have insurance that covers chiropractic, we will gladly give you receipts to get reimbursed quickly. If needed for insurance claims, we can email you a monthly statement. Your agreement with your insurance company is between you and them. Income tax statements are provided annually in February.

If a special situation arises, such as an auto accident or a worker's compensation injury and you choose to utilize that coverage, a new examination will need to be performed and you will be charged our regular office fees until such claim is settled. We will help you get reimbursed quickly on these claims. Depending on the situation, we may bill the insurance company directly. Once the claim is complete, your adjustment plan will be re-activated.

I have read and I understand the above policies.

_____

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Name: _____ **Date:** _____

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION

There are risks and possible risks associated with chiropractic examinations used by Doctors of Chiropractic and their staff. In particular you should note:

- While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of their examination.

I acknowledge that if I choose not to consent to all and/or part of the examination I will have ample opportunity to discuss with the doctor further options. I also understand that without a thorough examination, no treatment will be provided to me. I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic examination in general, options and recommendations in particular for my condition.

_____ _____
Patient Signature or Legal Guardian Witness Signature

PARENTAL INFORMED CONSENT TO CHIROPRACTIC EXAMINATION

Child's Name: _____ **Date:** _____

There are risks and possible risks associated with chiropractic examinations used by Doctors of Chiropractic and their staff. In particular you should note:

- While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of their examination.

I acknowledge that if I choose not to consent to all and/or part of the examination I will have ample opportunity to discuss with the doctor further options. I also understand that without a thorough examination, no treatment will be provided to my child. I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic examination in general, options and recommendations in particular for my child's condition.

_____ _____ _____
Mom - Signature Dad - Signature Witness Signature

If shared parenting, do you have sole authority for children's health decisions? Yes / No _____ (initials)