In Line Family Chiropractic
920 Yonge St. Box 1030 Walkerton, ON N0G 2V0 519-881-3443

Date:_____

Personal History

Name: _____ Address:_____
City:_____ Province:_____ Postal Code:_____
Home Phone:_____ Cell Phone:_____ May we text this number? Y N
Work:_____ Birth date: _____(d/m/yr) Age:_____ Sex: M F
Business/employer:_____ Type of work/Position:_____
Marital Status: Married Single Widowed Divorce Separated Other
E Mail Address: _____(Used **ONLY** to send monthly newsletter/office events)
Name of Spouse: _____ Names of children:_____
Name and number of Emergency contact: _____
Medical doctors name: _____ Last visit:_____ Last physical date:_____
How did you hear about our office? ☐ Google ☐ yellow pages ☐ newspaper Ad ☐ lecture/program
☐ office website ☐ radio Ad ☐ existing patient; referred by _____ ☐ other _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve. Please take the time to be as complete as possible:

Current Health Conditions

Current Complaint or Crisis(s): If no current crisis, what is the reason for your visits today?

_____
_____
Please describe how this happened:_____
Type of treatment:_____ Results:_____
When did this condition begin?_____ Has this condition occurred before? When ? _____
Is this condition: ☐job related ☐auto-related ☐home injury ☐fall ☐other _____
What aggravates your condition: ☐ sitting ☐ standing ☐ bending ☐ lifting ☐ lying down ☐ walking ☐ cold
☐ other _____
What relieves your condition: ☐ ice ☐ heat ☐ bed rest ☐ massage ☐ medication_____ ☐other_____
Is it getting: ☐ worse ☐ better ☐ constant ☐ comes/goes ☐ other_____
Character of pain: ☐sharp ☐ dull ☐ ache ☐ pins/needles ☐ numb ☐ burning ☐ constant ☐ intermittent
Please describe how it feels when this problem is at it worst:_____
Indicate your level of pain: least 1 2 3 4 5 6 7 8 9 10 worst
How does this problem interfere with your ability to: work?_____
enjoy social time?_____ enjoy hobbies/sports_____
At its worst, how old does it make you feel? _____
If you don't get this problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
Drugs/medication you now take: ☐ nerve pills ☐ pain killers/muscle relaxors
☐ insulin ☐ blood pressure ☐ other _____
Do you suffer from other conditions other than your current complaint?_____
Do you exercise? ☐ Yes ☐ No If yes, what type: _____
On a scale rate your commitment to correcting this problem: least 1 2 3 4 5 6 7 8 9 10 highest
Have you had x-rays taken in the last six months? ☐ Y ☐ N If yes, of what and where?_____

Past Health History

Major surgery/operations: ☐appendectomy ☐tonsillectomy ☐gallbladder ☐hernia ☐back surgery
☐broken bones ☐other:_____
Childhood traumas _____ Sports injuries_____
Motor vehicle accidents _____ Work injuries_____
Hospitalizations (other than above) _____
Own birth process ☐ natural ☐ forceps ☐ induced ☐ cesarean ☐ breach ☐ other_____
Previous chiropractic care: ☐ none ☐ Doctor's name and date of last visit _____
Chiropractor's comments

Family Health History

Does any member of your family suffer from: the same condition Y N Cancer Heart disease Stroke Other_____
Have any of your children had a spinal check up? Yes No If yes, where & when _____

Below is a list of diseases/conditions which may seem unrelated to the purpose of you appointment. However, these questions must be answere fully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases/ conditions you have ever had:

- pneumonia
- mumps
- chicken pox
- influenza
- polio
- aids
- measles
- anemia
- Cancer
- small pox
- epilepsy
- thyroid
- diabetes
- tuberculosis
- rheumatic fever
- pleurisy
- arthritis
- whooping cough
- mental disorder
- heart disease
- lumbago
- eczema

Check any of the following you have had in the past 6 months:

Musculo-skeletal Code

- heartburn
- arm pain
- neck pain
- low back pain
- pain between shoulders
- gas/bloating after meals
- joint pain/stiffness
- walking problems
- difficult chewing/clicking jaw
- black/bloody stool
- colitis

Nervous System Code

- nervous
- fainting
- numbness
- convulsions
- paralysis
- dizziness
- stress
- forgetfulness
- cold/tingling extremities
- confusion/depression

CVR Code

- lung problems/congestion
- heart problems
- irregular heart beat
- chest pain
- stroke
- ankle swelling
- short breath
- varicose veins
- blood pressure problems

General Code

- fatigue
- fever
- headaches
- allergies
- loss of sleep

EENT

- ear aches
- sore throat
- stuffed nose
- hearing difficulty
- dental problems
- vision problems

Gastrol -Intestinal Code

- general stiffness
- frequent nausea
- vomiting
- diarrhea
- constipation
- hemorrhoids
- poor/excessive appetite
- excessive thirst

Genito-Urinary Code

- bladder trouble
- painful/excessive urination
- discolored urine

Females Only

When was your last period?

_____

Are you pregnant?
Y N Not Sure

Intake

- coffee
- tea
- alcohol
- cigarettes
- white sugar

Personal satisfaction with diet

- satisfied
- highly satisfied
- dissatisfied
- highly dissatisfied

Do you exercise regularly?

Yes No

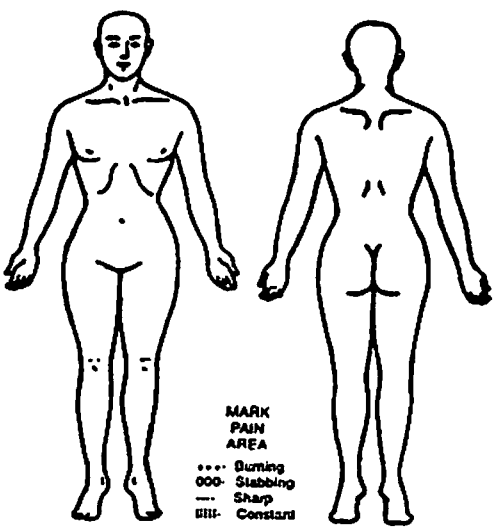
Lifestyle Stress

- high
- moderate
- very little

Male/Female Code

- menstrual irregularity
- menstrual cramping
- vaginal pain/infection
- breast pain/lumps
- prostate/sexual dysfunction

Please mark areas of pain or injury on the pictures below and give a word description of the symptom you are experiencing in those areas



Your oldest grandparent on record lived to the age of _____. Still living Deceased

Upon the completion of your first visit, you will receive a Report of Findings to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Report so you can choose the level of participation that supports you in reaching all of your health goals.

As part of my chiropractic care, I would like to:

Feel better quickly Have a healthier spine and nervous system Live a healthier lifestyle

_____ _____
Signature Date

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Office Fee Schedule and Financial Policy

Service	Adult	Child/Student
Consultation	N/C	N/C
Initial Exam	$100	$50
Adjustment	$39	$24
Initial ABC Treatment (New Patient)	$135	$100
Initial ABC Treatment (Existing Patient)	$105	$105
ABC Adjustment	$50	$50
Endonasal Treatment	$50	$50
Dynamic Exam and Spinal Scan	$30	$20
Low Volt Therapy	$2.50/minute	$2.50/minute
Initial Exam Laser/Low Volt Therapy	$50.00	$30.00
Laser Therapy	$45.00/session	$45.00/session
Ion Cleanse	$35.00	$35.00

Orthotics: One Pair - $450.00 Two Pair - $715.00

Massage:	One hour initial	$85.00	Half Hour Initial	$61.00	45 Minute Initial $72.00
	One hour	$70.00	Half Hour	$46.00	45 Minute $57.00

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 Active Life 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 Active Life Plan in advance.** These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Symptom Care, Corrective Care and Supportive Care options. Details of these plans will be discussed with you during your Report Of Findings.

- **Benefits / Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis, and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

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 active life plan will be re-activated.

I have read and I understand the above policies.

Patient Signature Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

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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:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of their examination.
b) Patients with skin sensitivity may react adversely to the alcohol swab used to perform the EMG study.

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 of Signature

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains, sprains as a result of manual therapy techniques. Although, uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
d) There are infrequent reported cases of burns or skin irritation in association with the use of some type of electrical therapy offered by some doctors of chiropractic.
e) Because we are a current, up to date office that prides ourselves on working with the latest technique models to help advance patient care, at times some of the techniques that we use in this office may be considered experimental.
f) We are a multi-doctor chiropractic office so at any time you may be adjusted by a different doctor including associates and/or locum doctors. The quality of your care depends on consistency. All of our doctors are trained to detect and adjust subluxation with the highest of quality. They will keep accurate records so that we all are aware of what was done on each visit and proper follow up can be provided.

_____ _____
Patient Signature or Legal Guardian Witness of Signature