

**Patient Information (please print clearly)**

Name: \_\_\_\_\_ Date of Birth: mm/dd/yyyy \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

*Please consider giving us a daytime phone number, in the event we need to reach you the same day as your appointment.*

Phone: (H) \_\_\_\_\_ (M) \_\_\_\_\_ (B) \_\_\_\_\_

Gender:  Female  Male Occupation: \_\_\_\_\_

Email: \_\_\_\_\_ Would you like to receive our monthly e-newsletter?  Yes  No

Where did you find our number? \_\_\_\_\_

If online, what site referred you?  Google  Facebook  Instagram  Twitter  Other: \_\_\_\_\_

Emergency Contact: (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Phone number) \_\_\_\_\_

**Billing Information**

Is your complaint related to a motor vehicle accident?  No  Yes *If Yes, please fill out an MVA Intake Form as well.*

Is your complaint a WSIB claim?  No  Yes *If Yes, please fill in the following:*

Date of accident: \_\_\_\_\_ Social Insurance Number: \_\_\_\_\_ WSIB Claim Number: \_\_\_\_\_

Employer name and phone number: \_\_\_\_\_

**Current Health Condition**

Current health complaint(s): \_\_\_\_\_

When did this begin? \_\_\_\_\_ Has the condition been getting:  Worse  Better  Stays the same

Has the condition occurred before?  No  Yes When? \_\_\_\_\_

Is the condition:  Job related  Auto related  Home injury  Fall  Other: \_\_\_\_\_

What does it feel like:  Sharp  Dull  Ache  Pins & needles  Numb  Burning  Other: \_\_\_\_\_

Frequency of pain:  Constant  Intermittent If intermittent, how often? \_\_\_\_\_

How long does each episode last? \_\_\_\_\_ When was your last episode? \_\_\_\_\_

Circle a number to indicate the severity of your pain: (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

What aggravates the condition? \_\_\_\_\_

What makes the condition feel better? \_\_\_\_\_

Does your pain radiate anywhere (e.g. into arms or legs)?  No  Yes Where? \_\_\_\_\_

What activities are you unable to do because of this condition? \_\_\_\_\_

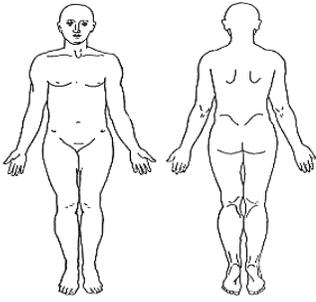
Have you had any previous injuries to the area of your complaint?  No  Yes When? \_\_\_\_\_

Have you seen another health professional for this condition?  No  Yes Who? \_\_\_\_\_

What level of improvement do you expect from Chiropractic treatment of your condition:  0%  25%  50%  75%  100%

***please turn over...***

Indicate areas of pain or discomfort:



Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health History**

Have you seen a Chiropractor before?  No  Yes If yes, when was your last treatment? \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Phone: \_\_\_\_\_

List other current therapies (i.e. physiotherapy): \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Last physical: \_\_\_\_\_

Current supplements/medications (conditions they treat): \_\_\_\_\_  
\_\_\_\_\_

Previous fractures, surgeries, or hospitalizations (Please list and date): \_\_\_\_\_  
\_\_\_\_\_

Please list the presence and location of any internal pins, wires, artificial joints or special equipment: \_\_\_\_\_  
\_\_\_\_\_

List any medical problems that other doctors have diagnosed: \_\_\_\_\_

Motor Vehicle Accident?  No  Yes Date: \_\_\_\_\_

Other accident(s) and date(s): \_\_\_\_\_

**Exercise level:**

- Sedentary (no exercise)
- Mild (e.g. Climb stairs, walk 3 blocks, golf)
- Occasional (e.g. work or recreation less than 4x/week for 30 min)
- Regular, vigorous (e.g. work or recreation 4x/week or more for 30 min)

**Other problems:**

- Skin  Nose  Bladder  Chest/Heart  Head/Neck
- Eyes  Throat  Intestines  Circulation  Other: \_\_\_\_\_
- Ears  Lungs  Bowels  Back

**Recent changes in:**

- Weight  Energy level  Sleep Patterns

**For Men Only:**

- Do you usually urinate during the night? .....  No  Yes If Yes, number of times: \_\_\_\_\_
- Any blood in your urine? .....  No  Yes
- Any kidney, bladder, or prostate infections in the last 12 months? .....  No  Yes
- Do you have any problems emptying your bladder completely? .....  No  Yes
- Any testicle pain or swelling? .....  No  Yes
- Date of last prostate and rectal exam: \_\_\_\_\_

**For Women Only:**

- Age of onset of menstruation: \_\_\_\_\_ Date of last menstruation: \_\_\_\_\_ Length of cycle: \_\_\_\_\_
- Heavy periods, irregularity, spotting, pain or discharge? .....  No  Yes
- Are you pregnant or breast-feeding? .....  No  Yes
- Have you had a D&C, hysterectomy, or Caesarean section? .....  No  Yes
- Any urinary tract, bladder, or kidney infections in the past year? .....  No  Yes
- Any blood in your urine? .....  No  Yes
- Any problems with control or urination? .....  No  Yes
- Any recent breast tenderness, lumps, or nipple discharge? .....  No  Yes
- Date of last pap smear and rectal exam: \_\_\_\_\_

## Cancellation & Fee Policy

For a full detailed price list: [www.wellnessforthebody.com](http://www.wellnessforthebody.com)

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, there is a charge of \$45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the full regular fee.

Payment is due at the time services are rendered. This policy applies to all our patients. Patients with extended health care coverage should note, our office does not file claims on your behalf, nor bill your insurance company directly.

I understand and am aware of the Cancellation & Fee Policy. I also agree that if I am late for my appointment, I will receive the remainder of the appointment time and will be responsible for the full payment of the scheduled appointment.

Patient Name (Please Print)	Signature of Patient (or Legal Guardian)	Date
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## Privacy Policy

Privacy of personal information is important to Wellness for the Body. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

### Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

### Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

### Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

I have reviewed the above information that explains how our clinic will use my personal information. I agree that Wellness for the Body can collect, use, and disclose my personal information as set out above in the College's privacy code.

Patient Name (Please Print)	Signature of Patient (or Legal Guardian)	Date
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***please turn over...***

## 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:

- o 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.
- o 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.
- o 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.
- o 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.
- o 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.
- o 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.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signature of Patient (or Legal Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Chiropractor

\_\_\_\_\_  
Signature of Chiropractor

\_\_\_\_\_  
Date