KAWARTHA FAMILY CHIROPRACTIC CLINIC

Dr. Nicole Loucks
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Kawartha Family Chiropractic Clinic

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Welcome To Our Office

Outline of Procedures for New Patients

All new patients are requested to fill out a confidential ***"Patient Health Record".***

Step Two

Your first ***"Consultation"*** with the doctor to discuss your concerns.

Step Three

You will receive a ***"Chiropractic Examination"*** to determine if chiropractic care is appropriate for your condition.

Step Four

An in-depth, technologically-advanced assessment of your nerve and energy system to determine how well your brain is communicating with your body. Any interference to this communication will be measured by ***Surface Electromyography*** which studies ***Muscle Function, Dermothermography*** which illustrates ***Inflammation*** and ***Autonomic Nervous System Function, Bilateral Weight Scales*** to determine weight distribution asymetries indicative of spinal abnormalities, and a ***Computerized Gait Analysis*** to study effects on posture. As well, if indicated, ***X-rays*** will be taken to visualize the location of spinal problems.

Step Five

If your case requires immediate attention, ***First Day Chiropractic Procedures*** will be administered.

Step Six

You will be advised as to a time you can return for a ***"New Practice Member Orientation"*** (N.P.M.O.) with the doctor / staff. Our records show that those patients who respond most rapidly to care are those who have learned to help themselves. We give you, your family and friends the opportunity to learn what you can do to help us return you to health more quickly and cost effectively, and what one needs to do to stay healthy.

Step Seven

You will be advised as to a time you can return for your ***"Report of Findings"*** when your doctor will inform you as to your examination results and whether or not your case has been accepted. If accepted your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step Eight

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the ***maximum possible improvement has been obtained.***

To save time and allow us to better serve you, please complete all questions on the next pages. Thank You.

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Date	Patient No.

Personal History

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Birthdate: _____ Age: _____

Email address _____ Birthsex: ☐M ☐ F Gender: _____

Extended Health Coverage: ☐ Yes ☐ No Company: _____ Family Physician _____

Business / Employer: _____ Type of Work: _____

Business Phone: _____ Circle One: Married Single Widowed Divorced Separated Other No. of Children ____

Name and Number of Emergency Contact: _____ Relationship: _____

Who may we thank for referring you to this office: _____

Current Health Condition

Current Complaint: _____

Are you here for: ☐ Chiropractic Care ☐ Other ie. Laser, Acupuncture, Naturopathic Medicine, Orthotics

What are your expectations from your care here? _____

Other Doctors seen for this condition: ☐ No ☐ Yes Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No

Is condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other _____

Date of Accident: _____ Time of Accident: _____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes / Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent

Please describe how it feels when this problem is at its worst. _____

Please place an X on the grade indicating the severity of your pain _____ LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Compare this problem at its worst and a time when you feel great. How does this problem at its worst interfere with:

Your ability to work? _____

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or 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 you now take: ☐ Nerve Pills ☐ Painkillers / Muscle Relaxers ☐ Blood Pressure Medicine ☐ Supplements
☐ Insulin ☐ Other: _____

Do you suffer from any condition other than that for which you are now consulting us? _____

_____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem. _____

Have you had X-rays taken in the last six months? ☐ Yes ☐ No If, yes, where? _____

Past Health History

Please check or describe:

Major Surgery / Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: _____

Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injuries ☐ _____

Hospitalization (other than above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's name and approximate date of last visit: _____

Previous Physiotherapy: ☐ Yes ☐ No Previous Massage-Therapy: ☐ Yes ☐ No

Family Health History

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____

Have your children ever had a spinal check-up? ☐ No ☐ Yes If yes, where and when? _____

_____

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

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Other

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

Musculo-Skeletal Code

- ☐ Low Back Pain
- ☐ Gas / Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black / Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing / Clicking Jaw
- ☐ General Stiffness
- ☐ Other

Nervous System Code

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress
- ☐ Other

C-V-R Code

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion / Asthma
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Other

General Code

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Other

EENT Code

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Other

Gastro-Intestinal Code

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Other

Male / Female Code

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction
- ☐ Other

Genito-Urinary Code

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Females Only

When was your last period? _____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Personal Satisfaction with Diet

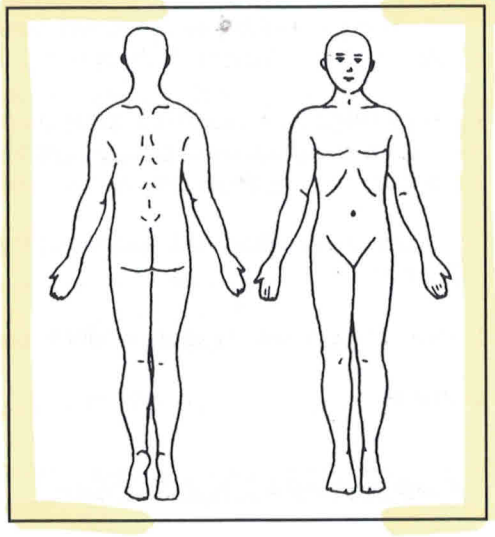
- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

- ☐ Yes ☐ No
- ☐ Recreational Activities

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little



Please outline on the diagram the area of your discomfort and any radiation of pain.

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition ***(Relief Care)***. Others are interested in having the *cause* of the problem as well as the symptoms corrected and relieved ***(Corrective Care)***. Still others want whatever is malfunctioning in their bodies brought to the *highest state of health* possible with chiropractic care ***(Preventative Care)***. These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his prepared recommendation is an incorporation of all three phases. *How long you choose to benefit from Chiropratic is always up to you.*

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Preventative Care** (Life Enhancement & Wellness Care)	☐ **Corrective Care** (Removing Cause & Re-modelling Soft Tissue)	☐ **Relief Care** (Band-Aid Care Only)	☐ Check here if you want the doctor to select the type of care appropriate for your condition.

Please read carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures ie., laser therapy, orthotic assessment and correction including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
Informed Consent to Chiropractic Treatment FORM L

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 or 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. Recent studies suggest 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 adjustment, 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 types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read the consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic exam and treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:_____**

(please print) **(please print)**