

III. Health Information

Are you currently taking any medications? Yes No

If yes, please list them: _____

Are you currently taking any vitamins and supplements? Yes No

Have you ever had any serious illness/surgeries or been hospitalized? If so, please list details:

List all serious trauma, accidents, or injuries _____

Please list any X-rays with dates when they were taken

Please list any allergies

Do you wear: Arch supports or orthotics Heel lifts

Is there a family history of any of the following?

	Heart Disease	Arthritis	Cancer	Diabetes	Autoimmune conditions	Other (please list)
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Females only)

Are you pregnant? Yes No

Do you have any problems with your menstrual cycle?

Have you reached menopause? _____ Surgical or physiological? _____

Have you had a Mammogram? Yes No

If yes, when was it performed? _____

What were the results? _____

Are you currently, or have you in the past, been on hormone replacement therapy? Yes No

Are you currently taking oral contraceptives? Yes No

Have you had a bone mineral density test? Yes No

If yes, when was it performed and what were the results? _____

IV. Personal/ Social History

Do you participate in a regular exercise program? If yes, what type of activity and how many hours per week? _____

What other interests/ hobbies do you enjoy? _____

Do you eat a balanced diet? _____ Describe _____

Do you get enough sleep? _____ If no, is it due to pain? _____ How many hours? _____

Have there been any changes in your bowel or bladder habits? _____

Do you smoke? Yes No If yes, how many cigarettes per day? _____ For how long? _____

Have there been any significant stressors in your life lately? _____

How do you handle stress? _____ Has this changed recently? _____

V. Health History

Have you ever experienced or been diagnosed with any of the following? Please circle those which apply.

- | | | | | |
|---------------------|--------------------------|----------------------|----------------------------|--------------------|
| Alcoholism | Diarrhea or constipation | Heart Disease | Numbness or tingling | Sinus conditions |
| Anemia | Diabetes | Herniated Disc | Osteoporosis | Sleep disturbance |
| Anorexia or Bulimia | Difficulty hearing | Herpes | Overall weakness | Small Pox |
| Appendicitis | Difficulty walking | High Cholesterol | Pacemaker | Sore throat |
| Arm pain | Digestive disorders | Irregular heartbeat | Pain between shoulders | Spinal injury |
| Arthritis | Dizziness or Fainting | Jaw pain | Parkinson’s Disease | Stroke |
| Asthma/allergies | Eczema | Joint pain/stiffness | Pinched Nerve | Suicide Attempt |
| Back pain | Emphysema | Kidney condition | Pleurisy | Swollen ankles |
| Black/bloody stool | Epilepsy | Liver Disease | Pneumonia | Thyroid Problems |
| Bladder problems | Excessive thirst | Low back pain | Polio | Tonsillitis |
| Bleeding Disorders | Fatigue | Lung disease | Poor or excessive appetite | Tuberculosis |
| Breast Lump | Forgetfulness | Measles | Productive cough | Tumors, Growths |
| Bronchitis | Fractures | Mental disorders | Prostate Problems | Typhoid Fever |
| Cancer | Frequent nausea | Miscarriage | Prosthesis | Ulcers |
| Cataracts | Gain or loss of weight | Mononucleosis | Psoriasis | Vaginal Infections |
| Chemical Dependency | Glaucoma | Multiple Sclerosis | Psychiatric Care | Venereal Disease |
| Chicken Pox | Gonorrhea | Mumps | Rheumatic Fever | Vision problems |
| Chronic infection | Gout | Neck pain | Rheumatoid Arthritis | Vomiting |
| Convulsions | Headaches | Night sweats | Shortness of breath | Whooping Cough |
| Depression | | | | |

Do you have a history of high blood pressure? Yes No

Is there anything else the doctor should know about your health?

VI. Office Payment Policies

As posted, our fees are as follows:

Initial Visit (Examination and 1 st treatment)	\$70
Second visit/Report of Findings	\$55
Subsequent visits	\$45
Extended Visit: Intended for Acute Situations requiring additional care or a closer examination of two or more areas	\$75

Your appointment time is reserved for you. Please note that to cancel or reschedule your appointment, a minimum of 24 hours notice is required to avoid a late cancellation fee of \$20.

VII. Coverage for Chiropractic Treatment

Claims for Worksafe BC, the Insurance Corporation of British Columbia, and private insurance carriers may cover part or all of your treatment expenses.

If your Worksafe BC claim is accepted, we will reimburse to you for the payments we receive from Worksafe BC. If for any reason, WCB does not accept your claim, you are responsible for all charges related to the treatment.

The Insurance Corporation of British Columbia will pay you directly for a portion of your treatment costs. A cheque will be mailed to your home address.

To receive reimbursement from private insurance carriers, mail the required claim form along with your receipt for treatment to the insurance company.

VIII. Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I have read the above and I accept full responsibility for payment of chiropractic treatment fees.

Signature of Patient (or parent of a minor) Date



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. Research studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, the stroke is already in progress. However, you are being informed of this reported association because a stroke may causes 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 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 this 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 treatments recommended to me by my chiropractor, including any recommended spinal adjustment.

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: _____
(please print)

Name: _____
(please print)

CCPA.06.05