Uxbridge Chiropractic Centre 26 Brock Street East, Uxbridge, Ontario L9P 1P1

Confidential Patient History Information

Name _____ Date _____ / _____ / _____ dd/mm/yyyy

Address _____City _____ Prov. _____Postal Code _____

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth: dd_____ mm_____ yyyy_____ Age_____ Marital Status: S M D W Sep. (circle one)

Email_____Would you like email appointment reminders? □ Yes □ No

Occupation_____ Employer_____

Spouses' Name_____ Children_____

Please tell us who referred you._____ or how you heard about our office.

□ Family member □ Friend □ MD □ RMT □ Sign □ Yellow Pages □ Local Phone Book □ Other

Family Doctor_____ Specialists_____

Other Health Providers_____

Prior Chiropractic Care: Name_____ When_____Why_____

Reason for your Visit: What is your major complaint? _____

When did it start? _____ Have you had this condition before? _____

Is this condition interfering with your: □Work □Sleep □Daily Routine □Exercise □Other_____

Character of your pain: □sharp □dull ache □burning □throbbing □numbness □stiffness □cramping □pressure

Is it getting: □worse □staying the same □better Is it: □constant □comes and goes □radiating

Please circle the severity of your pain: least - 0 1 2 3 4 5 6 7 8 9 10 – worst

Do you have any secondary complaints?_____

Previous serious accidents/injuries with date(s) _____

Are you wearing: □heel lifts □shoe inserts □arch supports □custom orthotics _____ for how long?

Is this a work-related injury (WSIB claim)? □ Yes □ No If yes, date of injury: _____

Is this a Motor Vehicle injury claim? □ Yes □ No If yes, date of accident: _____

Do you have Extended Health coverage? □ Yes □ No Company Name_____

Would you like us to direct bill your insurance company? □ Yes □ No

If yes, Policy # _____ Plan Member ID # _____

What are your treatment goals? (check all that apply)

□ Relief care only – reduces pain and stabilizes your condition.

□ Rehabilitative care – to correct the underlying problem, improve muscle strength and joint function.

□ Preventative care – to maintain the benefits you have achieved and reduce the likelihood of future problems.

Family Health History

Many health problems are the result of hereditary factors. Information about your family members will give us a better understanding of your total health picture.

Name	Relationship	Past and Present Health Problems

Lifestyle Factors – Please check the appropriate box

	None	Light	Moderate	Heavy
Exercise				
Sleep				
Stress				
Tobacco				
Alcohol				
Caffeine				
Junk food				

Heath Screening and Testing

Test	Date	Of what region	Results
X-rays			
Cat Scan			
MRI			
Bone Density			

Medications

Reason	Name	Reason	Name
Pain Relief		Diabetes	
Anti-inflammatory		Thyroid	
Muscle relaxant		Other	
Blood pressure			
Blood thinner			
Heart			
Cholesterol			

Supplements

Surgical History

Surgery	Date	Surgery	Date
Hip replacement L R		Bowel	
Knee replacement L R		Thyroid	
Spinal surgery		Gallbladder	
Fractures(surgical repair)		C-section	
Shoulder L R		Hysterectomy	
Knee L R		Other	
Carpal tunnel L R			
Heart			

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 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:

- **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.
- **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.
- **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 or other minor care.
- **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.
- **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 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.
- **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 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 with 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.

Name (Please print): _____

Signature of Patient: _____ Date: _____
(or legal guardian)

Signature of Chiropractor: _____ Date: _____

CONFIDENTIAL HEALTH REPORT

Patient Name: _____

Please circle any conditions presently causing you problems. Please check (X) any conditions that were a problem in the past.

General Symptoms
Headache/Migraine
Fever
Sweats/Chills
Fainting
Dizziness/vertigo
Loss of sleep
Tremors/seizures
Anxiety/depression
Mood swings
Memory changes
Difficulty concentrating
Numbness/weakness
Pins and needles
Fatigue
Neuralgia (nerve pain)
Loss of balance

Muscles and Joints
Osteoarthritis
Arthritis _____(type)
Osteoporosis
Red or swollen joints
Bursitis/Tendonitis
Low back pain
Sciatica
Neck pain or stiffness
Pain between shoulders
Pain and numbness in:
Shoulders/arms
Elbows/hands
Hips/legs
Knees/feet
Painful tail bone
Poor posture
Spinal curvature
Jaw pain/clicking
Fibromyalgia
Multiple sclerosis
Parkinson's

E.E.N.T.
Vision changes
Eye pain
Deafness/hearing aids
Frequent colds
Sinus/ear infections
Enlarged glands
Tinnitus (ringing ears)
Nose bleeds
Thyroid

Skin
Rashes/itching
Bruise easily
Dryness
Eczema/Psoriasis

Respiratory
Chronic cough
Spitting up blood
Chest pain
Shortness of breath
Snoring
Sleep apnea
Asthma
Pneumonia
Tuberculosis

Cardiovascular
Rapid/irregular heartbeat
Pacemaker
High blood pressure
Low blood pressure
Angina
Heart attack
Stroke/TIA
High cholesterol
Poor circulation
Varicose veins
Swollen ankles
Blood clotting/bleeding disorder

Genitourinary
Difficulty with/frequent urination
Blood in urine
Kidney infection/stones
Prostate problems

For Women Only
Painful menstruation/cramping
Menopause symptoms
Irregular cycle
Pregnant Yes ◯ No ◯
Post-menopausal

Gastrointestinal
Diabetes
Low blood sugar
Anemia
Poor appetite
Indigestion/heartburn
Excessive thirst
Bloating/gas
Nausea/vomiting
Abdominal pain
Ulcers
Constipation/Diarrhea
Colitis/Irritable bowel
Jaundice/Hepatitis A B C
Gall bladder

Cancer:
_____
_____
_____

Allergies
Environmental: _____
_____
Food: _____
Drug: _____
Latex Yes ◯ No ◯

Dr. Jeff Kinnersly
Dr. Melissa Mullett
26 Brock St E, Uxbridge ON L9L 1P1

UXBRIDGE CHIROPRACTIC CENTRE

26 Brock St. E., Uxbridge, ON
L9P 1P1
905-852-7704

Dr. Jeff Kinnersly – Chiropractor

Dr. Melissa Mullett – Chiropractor

Dr. Kendra Clifford – Naturopath

Patient Consent for Collection, Use and Disclosure of Personal Information

Privacy and protecting your personal information is an important part and consideration at the Uxbridge Chiropractic Centre. This privacy policy outlines what we do to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Collection, use, storage, and destruction of your personal information complies with existing legislation, privacy protection protocols, and the standards of our regulatory bodies, The College of Chiropractors of Ontario and The College of Naturopaths of Ontario.

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To establish your health concerns, provide health care and advise you of your treatment options;
- To establish and maintain contact with you to book and confirm appointments and distribute health care information;
- To efficiently follow up with you for treatment, care and billing;
- To communicate with other treating health-care providers;
- To provide health information for insurance claim purposes
- To authorize electronic transmission and/or assign claim payments to provider for insurance claims processing
- To invoice for goods and services, and process credit card, debit and cheque payments;
- To enable us to contact you (including marketing purposes), by telephone, fax, e-mail and instant messaging and regular mail;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

Patient Consent

I, _____, have reviewed the above information that explains how Uxbridge Chiropractic Centre will use my personal information and the steps that are taken to protect my information.

Patient/Guardian Signature: _____

Date: _____