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_____ # of Children_____

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

• Family member • Friend • Doctor • RMT • Sign • Internet Search • 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.

Dr. Jeff Kinnersly, BSc., D.C. / Dr. Melissa Mullett, HBKin, D.C.

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				

Health 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			

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

Uxbridge Chiropractic Centre

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: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Updated: September 2025

CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about 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. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____	_____	_____
Patient/Guardian Signature	Date	Chiropractor Signature