In-Line Family Chiropractic

NEW PATIENT INTAKE

Name: _____ Date: _____

Address: _____City_____ Prov. _____ Postal Code_____

Phone Numbers: Home_____ Work_____ Cell_____

Date of birth _____Day/_____Month/_____Year Age:_____ F ☐ M ☐

Marital Status_____ # of children _____ Spouse's name _____

Occupation _____ Employer's name _____

AHC#_____Have you seen a chiropractor before? Yes No If yes, when? _____

Whom can we thank for referring you to our office? _____

Emergency contact + phone _____

Reason for appointment_____

When did your condition begin? _____

Have you ever had similar problems? Yes No

Have you had X-rays, MRI, or other tests for this condition? Yes No Which tests, when?

_____

Is this a Motor Vehicle Accident (MVA) Yes No

On what date did the accident occur? _____

Family doctor name: Dr. _____

Would you like to receive appointment reminders via email? Yes No

Email:_____

Email in our office is used for appointment reminders, receipts, front office correspondence, posture pictures, exercises and screenings. In accordance with Canada's anti-spam legislation you can unsubscribe at any time by letting our front office staff know you would not wish to receive correspondence in this way.

YOUR HEALTH SUMMARY

Please check all symptoms you've ever had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Pins and needles in arms
- ☐ Pins and needles in legs
- ☐ Dizziness
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Diarrhea
- ☐ Cold sweats
- ☐ Mood swings
- ☐ Allergies
- ☐ Poor posture
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Buzzing in ears
- ☐ Ringing in ears
- ☐ Depression
- ☐ Stiff neck
- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual pain
- ☐ Menstrual irregularity
- ☐ Heartburn
- ☐ Ulcers
- ☐ Arthritis
- ☐ Difficult digestion
- ☐ Heart condition
- ☐ Fainting
- ☐ Back pain
- ☐ Irritability
- ☐ Nervousness
- ☐ Tension
- ☐ Hot flashes
- ☐ Diabetes
- ☐ Bursitis
- ☐ Cancer
- ☐ Stroke
- ☐ Loss of balance
- ☐ Stomach upset
- ☐ Numbness in arms/fingers
- ☐ Numbness in feet/toes
- ☐ Cold hands
- ☐ Cold feet
- ☐ Fever

Are you pregnant?
Yes No

List any medications you are taking?

_____

_____

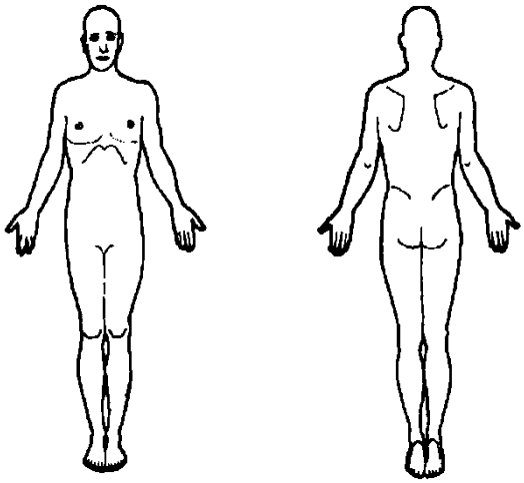
Health History Questionnaire

Patient name _____ **Date** _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ---------- Yes No
2. Hardening of the arteries (arteriosclerosis) ---------- Yes No
3. Diabetes ---------- Yes No
4. Tuberculosis ---------- Yes No
5. Cancer ---------- Yes No
   Where? _____
6. Heart or blood diseases ----------Yes No
7. Bone spurs on the neck bones (cervical sprain) ----------Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain)---------- Yes No
9. Have you or any of your relatives ever suffered a stroke? ---------- Yes No
10. Were you ever a smoker? ---------- Yes No
    From _____ to _____
11. Do you take medication on a regular basis?---------- Yes No
12. Visual disturbances (blurring, loss, double vision)---------- Yes No
13. Hearing disturbances (loss, ringing, other noise) ----------Yes No
14. Slurred speech or other speech problems ----------Yes No
15. Difficulty swallowing ---------- Yes No
16. Dizziness ---------- Yes No
17. Loss of consciousness, even momentary blackouts ---------- Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body?----------Yes No
19. Sudden collapse without loss of consciousness ----------Yes No

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by circling a number:

| 0 1 2 3 4 5 6 7 8 9 10 |

No pain Extreme pain

Name (PRINTED) _____

Patient Signature _____ Date _____

Dr. Craig Wing / Dr. Brandan Chretien 10434B 123 Street Edmonton, Alberta T5N1N7 780-455-5212

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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:

- **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 and 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 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.
- **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.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____.
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

Cancellation Policy

In-Line Family Chiropractic

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other healing spines that may have an immediate need to our care.

Missed, no show spinal check-up (adjustment) appointments: will be charged a donation of $10 to Australian Spinal Research Foundation. More than 3 missed appointments will be subject to the discontinuation of care with this office.

We strive to render excellent care to you and the rest of our patients. Your care and treatment is a priority to us. We also ask that you respect our time and expertise as well.

We are here to serve **you**, and to help **you** have a happy, healthy and prosperous life.

_____

Print name

_____

Signature

_____

Date

Office Fee Schedule

Consultation/ Exam	$100.00

Includes: Examination, Posture Analysis, Nervous System Function Evaluation (NASA supported), and Report of Findings.

Chiropractic Wellness Adjustment	$61.00
Progress Exam	$60.00

- Extended Health Insurance Plans: If you have additional coverage, we will give you all information you need to get reimbursed quickly. Simply send in your receipts and a claims form and your insurance company will communicate with you about your reimbursement.
- If you have been in a motor vehicle accident or have experienced an injury please inform us immediately to ensure you receive the necessary care.
- All fees are due at the time of service. Thank you!

I have read and understand the above policies.

_____ _____ _____

Print Name Patient Signature Date

We have created a chiropractic center dedicated to your over-all health as a human being. Our purpose is to remove interferences to the expression of life, and to reveal to those who are interested, the source of true health and manifestation of their fullest potential.

UNLEASH YOUR POTENTIAL!