



# YOUR HEALTH

Wellness Centre

200-1158 Winston Churchill Blvd  
Oakville, ON L6J 0A3

## Chiropractic New Complaint and Reevaluation Form

### Patient Information (please print clearly)

Name: \_\_\_\_\_ Date of Birth: mm/dd/yyyy \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Check here if there has been no change to your contact information since your last assessment. Please advise reception if there have been any changes

### Fee Schedule

Initial Assessment: \$100.00      Chiropractic Regular Visit: \$48.00 (age 12+)      Chiropractic Extended Visit: \$80.00  
 Chiropractic Regular with Acupuncture: \$80      Chiropractic Regular with Laser: \$63.00      Chiropractic Extended Visit with Laser: \$95.00

**We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning, appointments cancelled with less than 24 hours notice will be charged in full, unless the appointment is rescheduled within 48 hours.**

I have read the Your Health Wellness Centre financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. I HEREBY AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT YOUR HEALTH WELLNESS CENTRE.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Please Select One

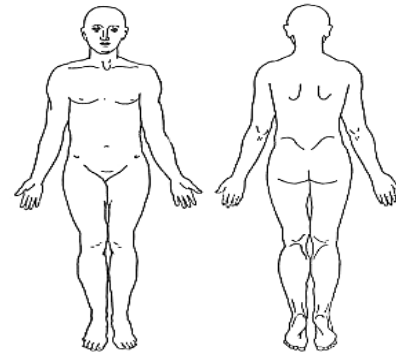
- \_\_\_ **Progress Evaluation:** I have been under active care and this is a periodic reevaluation
- \_\_\_ **New Condition:** I have been under care and a new or returning condition has emerged
- \_\_\_ **Maintenance Patient:** I am under maintenance care with a new or returning health issue
- \_\_\_ **Returning Patient:** After a period of inactivity, I have had a relapse or an all-new health issue

### Current Symptoms

In the diagrams below, please mark the areas on your body which you feel best represents the pain(s) or sensation(s) that you experience. Please include all areas. Use the symbols provided below.

Symbols:

Numbness	≡≡≡	Pins & Needles	***
			***
Burning	XXX	Sharp & Stabbing	///
	XXX		///
Dull & Aching	+++	Stiff & Tight	222
	+++		222



Please indicate the severity of your pain by circling a number below:

0	1	2	3	4	5	6	7	8	9	10
No pain								Unbearable pain		

When did it start? \_\_\_\_\_

How often do you feel it? \_\_\_\_\_

Does it affect other areas of your body? To what areas does the pain radiate/shoot/travel? \_\_\_\_\_

What makes the problem worse? (e.g. time of day, movements, certain activities) \_\_\_\_\_

What lessens the problem? \_\_\_\_\_





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## INFORMED 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 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
- 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. CCPA 09.14 Page 2 of 2

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.

**Instrument Assisted Soft Tissue Techniques and Myofascial Release Techniques** used in our office are types of cross fiber or transverse friction massage. They are a form of treatment used to “break up” or “soften” scar tissue, thus allowing for the return of normal function in the area being treated. Treatment may produce the following symptoms: local discomfort during the treatment, reddening of the skin, superficial tissue bruising, or post treatment soreness. These techniques are designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

**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.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature of patient (or legal guardian)

Date: \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Chiropractor

Date: \_\_\_\_\_ 20\_\_\_\_

**Informed consent to Acupuncture**

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, laser, electro-acupuncture, and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the acupuncturists or another duly authorized person in the clinic.

I have had the opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and am informed that, as with all health care, the practice of acupuncture possesses slight risks from treatment, including, but not limited to, temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to anticipate and explain all the risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known are in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures(s). I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name: (print) \_\_\_\_\_

(Signature) \_\_\_\_\_

Witness: (print) \_\_\_\_\_

(Signature) \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_