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: $110.00
Chiropractic Regular Visit: $50.00 (age 12+)
Chiropractic Extended Visit: $85.00
Chiropractic Regular with Acupuncture: $85
Chiropractic Regular with Laser: $70.00
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

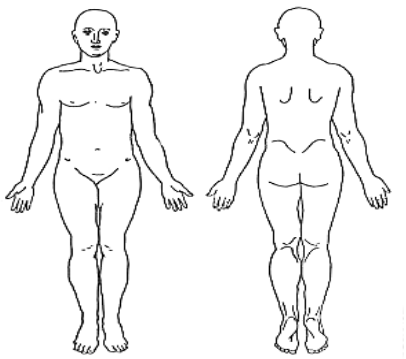
___ **Progress Evaluation:** I have been under active care and this is a periodic reevaluation
___ **New Condition:** I have been under care and a new or returning condition has emerged
___ **Maintenance Patient:** I am under maintenance care with a new or returning health issue
___ **Returning Patient:** 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 XXX	Sharp & Stabbing	/ / / / / /
Dull & Aching	+ + + + + +	Stiff & Tight	2 2 2 2 2 2



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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If this is a reassessment of an existing complaint, what percentage improvement have you noticed in your overall symptoms? _____

Anything else we should know about the problem? _____

Have there been any accidents, illness, trauma, or medical changes since your last assessment with us?

_____

Review of Systems (Identify any changes since your most recent evaluation with us)

	Worse	No change	Improved
Musculoskeletal system: such as osteoporosis, arthritis, neck pain, back problems, poor posture			
Neurological system: such as anxiety, depression, headache, dizziness, pins and needles, numbness			
Cardiovascular system: such as high blood pressure, low blood pressure, high cholesterol, angina			
Respiratory system: such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia			
Digestive system: such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea			
Sensory system: such as blurred vision, ringing in the ears, hearing loss, chronic ear infection			
Integumentary system: such as skin cancer, psoriasis, eczema, acne, hair loss, rash			
Endocrine system: such as thyroid issues, immune disorders, hypoglycemia, frequent infection			
Genitourinary system: such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms			
Constitutional system: such as fainting, low libido, poor appetite, fatigue, weight changes, weakness			

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____

Name: (print) _____ (Signature) _____

For Doctor's Use Only

☐ Verbal Consent received for Physical Examination Doctor: _____

Neuro UL LL

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M

R

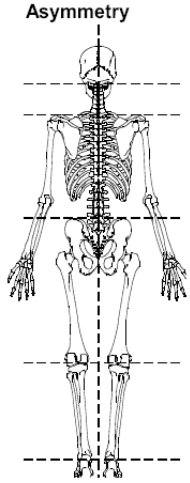
Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

Asymmetry



Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑↓), mark postural asymmetry

Tissue

Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

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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 Myofacial 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 MEETWITH 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)

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

_____ Date: _____ 20_____
Signature of Chiropractor

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_____