YOUR HEALTH

Wellness Centre

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

Pediatric Chiropractic New Patient Form

Patient and Guardian Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: ____

Name of parents/guardians: _____

Primary Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (M)_____

Email: _____ (to receive appointment reminders)

How did you find out about us? _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

Is your complaint related to a motor vehicle or WSIB accident? [ ] Yes [ ] No

Medical Doctor: _____ Phone: _____

[ ] I consent to YOUR HEALTH communicating with my medical doctor regarding my treatment.

Date of last medical appointment and reason: _____

Current Symptoms

What is your main complaint? _____

When did it start? _____ How often do you feel it? _____

Fee Schedule

Initial Assessment: $125.00	Chiropractic follow-up: $40.00 (up to age 12)	30 minute follow-up: $80.00
Special Needs Initial Visit: $125.00	Special Needs Follow-up visit: $80	Chiro. Follow-up with Laser: $60.00

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist. In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

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.

Custom-made orthotics will not be ordered for a patient until the patient has paid at least 50% of the item cost. We do realize that custom orthotics are an expensive part of treatment and we do make every attempt to control these costs. Our staff is available to assist patients with insurance benefit verification for such items.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with YOUR HEALTH to be a pleasant one and we hope this information will help to make it so.

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.

Signature of parent/guardian: _____ Date: _____

Patient Name: _____ Date: _____

HEALTH HISTORY

Previous fractures, surgeries, or hospitalizations (Please list and date):

History of Birth		
[ ] Hospital [ ] Birthing Centre [ ] Home [ ] Medical [ ] Midwife [ ] Normal Delivery [ ] Assisted Delivery If yes: [ ] Forceps [ ] Vacuum extraction [ ] C-section [ ] Induced labour	Duration of gestation: _____ weeks Duration of birth: _____ hours Medications delivered to mother during labour: _____ Birth Weight: _____ Birth Length: _____ APGAR: _____ (birth) _____ (5 min)	*Describe any complications at birth:*

Growth and Development	**Chemical Stressors**	
At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____ Sit alone? _____ Teethe? _____ Crawl? _____ Walk? _____	Was the child breast fed? _____ If yes, for how long? _____ Any food/juice intolerance? _____ _____ _____ Did mom smoke while pregnant? _____ Did mom drink while pregnant? _____ Did mom have any illness while pregnant? _____ _____ Did mom take any meds or supplements during pregnancy? _____ _____ Any invasive procedures during pregnancy? (e.g. amnio, U/S) _____ _____ Any pets/smokers in the home? _____ _____	*Describe any vaccinations and whether any negative reactions occurred:* *Describe number and type of medications (including antibiotics) and for what reason:*

Psychosocial Stressors	**Traumatic stressors**	
Any difficulties with lactation? _____ _____ Any difficulties with bonding? _____ _____ Any night terrors, sleep walking, difficulty sleeping? _____ _____ _____ Age of child entering daycare? _____ Average number of screen hours/week _____ Does child seem normal for age? _____ _____ _____	Any traumas during pregnancy? (e.g. falls, accidents) _____ _____ Any evidence of birth trauma? (e.g. bruises, odd shaped head, stuck in canal, long/short birth, cord around neck, respiratory depression) _____ _____ _____ Any falls from couches, beds, etc? _____ _____ _____ Weight of school backpack? _____ Approximate hours/week playing _____	*Describe any behavioural problems and age of onset:* *Describe any additional concerns:*

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PRIVACY POLICY

Privacy of personal information is important to YOUR HEALTH. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how our clinic will use my personal information.

I agree that Your Health Wellness Centre can collect, use, and disclose my personal information as set out above in the College's privacy code.

_____ _____

(Signature) (Signature of Witness)

_____ _____

(Print name) (Date)

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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_____