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New Patient Form

Date: _____ Name: _____

Health Care Number: _____ Date of Birth: _____
Day/Month/Year

Address: _____ Phone Number: _____
City: _____ Work Number: _____
Postal Code: _____ Cell Number: _____
Email: _____

Emergency Contact: _____
Emergency Number: _____

Do you have insurance? Yes ☐ No ☐ Occupation: _____

If so, who is your provider? _____
What is your policy and group number? _____

Name of your Family Doctor: _____

Phone Number or Clinic Name: _____

Do you consent to your health team at Balanced Chiropractic contacting your medical doctor to discuss relevant information regarding your treatment plan? Yes ☐ No ☐

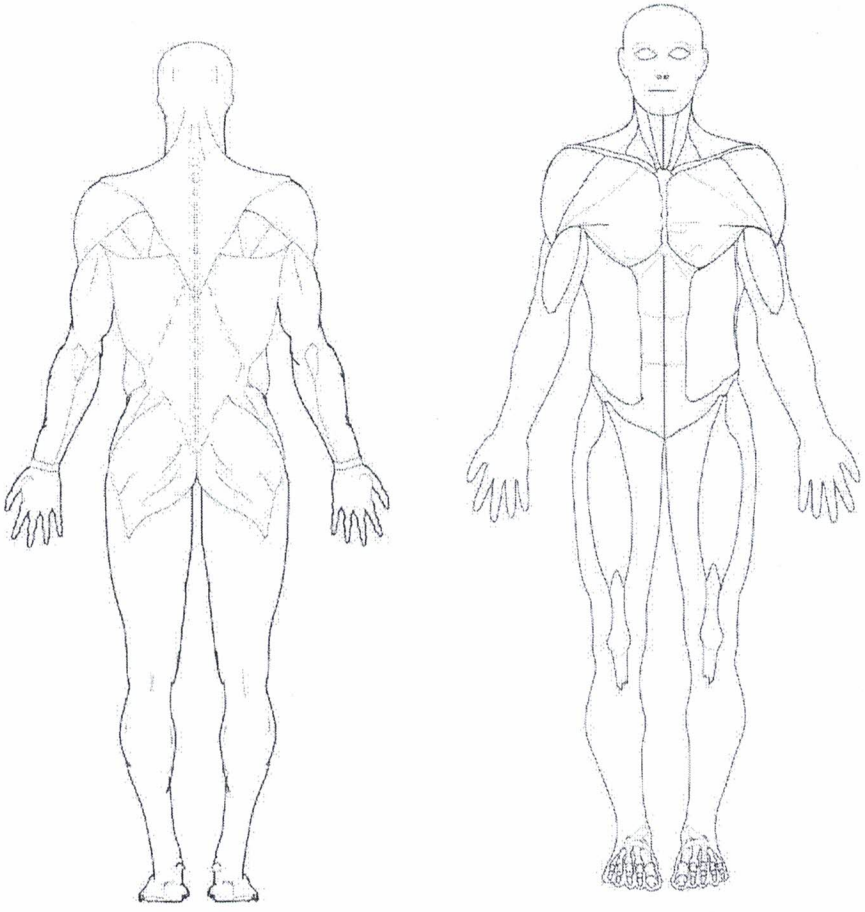
How did you hear about us? Please write down the name of the person if selected				
Friends/Family	☐		Newspaper / Print Articles :	
Other	☐		Chamber Directory ☐	Fort Sask Guide ☐
Welcome Wagon	☐	Phone Book ☐	Farm and Friends ☐	Sturgeon Creek Post ☐

Please complete these forms on both sides

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness: + + + + + Pins and needles: o o o o o Aching: ■■■■

Burning: x x x x x Stabbing: / / / / / / /



Please mark on the line below where you would describe your pain level today.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please see other side

Please check all answers and fill in the blanks where appropriate.

Reason for appointment:_____

When did your condition begin?_____

Have you ever had similar problems? ❑ yes ❑ no
Explain:_____

Have you had x-rays, MRI, or other tests for this condition? ❑yes ❑ no
If so, what kind of test and when?_____

Is your condition related to: Work? ❑ yes ❑ no
Has your employer been notified? ❑ yes ❑ no
Is this a WCB Claim? ❑ yes ❑ no
Motor Vehicle Accident? ❑ yes ❑ no
Date of Injury:_____
Is this a MVA Claim? ❑ yes ❑ no

Can you perform home activities? ❑ yes ❑ yes with help ❑ no
Can you perform work activities? ❑ all activities ❑ only some ❑ none

Please list any previous surgeries, illnesses, injuries (motor vehicle accident, etc):

_____

_____

_____

List all medications: (prescriptions, vitamins, herbal supports, BCP, aspirin, etc):

_____

_____

Have you had previous chiropractic care? ❑ yes ❑ no Doctor:_____
Have you had previous acupuncture care? ❑ yes ❑ no Doctor:_____

Patient History

Have you ever had a serious fall(s) or injury(ies)?	❑ yes	❑ no
Have you ever been knocked unconscious?	❑ yes	❑ no
Have you ever been under treatment for cancer?	❑ yes	❑ no
Have you experienced any changes in weight in the last year?	❑ yes	❑ no
Do you have any health problems that you feel are not of interest to the doctor that you have not disclosed?	❑ yes	❑ no
Have you or any of your relatives ever suffered a stroke?	❑ yes	❑ no

Below is a list of diseases that may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your course of treatment.

Please check all the following that you have been diagnosed with or told you have had:

❑ Rheumatic Fever ❑ Pleurisy ❑ Epilepsy ❑ Influenza ❑ Polio ❑ Arthritis
❑ Mental Disorders ❑ Diabetes ❑ Anemia ❑ Cancer ❑ TB ❑ Thyroid
❑ Chicken Pox ❑ Measles ❑ Mumps ❑ Pneumonia ❑ Blood Diseases
❑ Whooping Cough ❑ Small Pox ❑ Heart Disease ❑ Arteriosclerosis ❑ Eczema
❑ Bone spurs on the neck bones (cervical sprain)

Please check all the following you have experienced in the last 6 months:

❑ Visual disturbances (blurring, loss, double) ❑ Hearing disturbances (loss, ringing, etc)
❑ Slurred speech or other speech problems ❑ Loss of consciousness, even momentarily
❑ Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms or any other part of the body
❑ Sudden collapse without loss of consciousness ❑ Difficulty swallowing ❑ Dizziness

❑ Sore Throat
❑ Dental problems
❑ Ear Aches
❑ Painful or Excessive Urination
❑ Discolored Urine
❑ Prostate/Sexual Dysfunction

Please see other side

Please check all the following you have experienced in the last 6 months:

- ❑ Chest pain
- ❑ Heart problems
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Lung problems/congestion
- ❑ Blood Pressure problems
- ❑ Constipation
- ❑ Multiple Painful Joints
- ❑ Walking problems
- ❑ Arm pain
- ❑ Joint stiffness
- ❑ Low back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ General stiffness
- ❑ Clicking jaw
- ❑ Weight problems
- ❑ Poor/Excessive appetite
- ❑ Excessive thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Convulsions
- ❑ Hemorrhoids
- ❑ Abdominal cramps
- ❑ Heartburn
- ❑ Gas/bloating after meals
- ❑ Nervousness
- ❑ Paralysis
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Fainting
- ❑ Allergies
- ❑ Cold/tingling extremities
- ❑ Fatigue
- ❑ Loss of sleep
- ❑ Headaches
- ❑ Fever

Female Patients

- ❑ Bladder problems
- ❑ Menstrual irregularity
- ❑ Menstrual cramps
- ❑ Vaginal pain/infections
- ❑ Breast pain or lumps
- ❑ Other problems

Could you be pregnant? ❑ yes ❑ no Due Date:_____

Are you trying to conceive? ❑ yes ❑ no

Do you drink:

Coffee?	❑ yes	❑ no	_____cups per week
Tea?	❑ yes	❑ no	_____cups per week
Alcohol?	❑ yes	❑ no	_____drinks per week

Are you currently, or ever been, a smoker? ❑ yes ❑ no

From:_____ To:_____

Balanced Chiropractic Office Policies

Your Natural Health Centre

Please sign this form, acknowledging you have read the fee schedule and the record keeping process within our clinic.

Adult		
	Initial Exam and Treatment	$110
	Acupuncture Treatment	$90
	Cupping Treatment	$65
Senior (65+)		
	Initial Exam and Treatment	$105
	Acupuncture Treatment	$85
Child/ Student (19 months - 25 years – with Student ID)		
	Initial Exam and Treatment	$ 95
	Acupuncture Treatment	$ 75

Cancellation Policy: We require 24 hour notice of cancellation. Failure to do so will result in a $50.00 charge. Privacy Policy: Information is used to properly identify the individual, acquire x-ray results, order appropriate imaging (x rays, MRI's, CT's, Bone scan) assisting with WCB and third-party claims, and to provide the best health care possible. Your personal information is collected in accordance with the Health Information Act. Any or all healthcare information will only be disclosed outside the clinic at the direction of the patient.

Master File: Patient consents to the shared use of the patient's clinical notes file by other relevant/appropriate healthcare providers within the clinic only, in the form of a **Master Patient File.**

_____ _____

Patients Signature Date

Patient Consent Form

I _____ hereby request and consent to the application of acupuncture and/or other modalities (including cupping, gua sha, moxibustion, heat therapy, massage, electrical stimulation, and lifestyle/dietary advice).

I understand these practices are generally safe and are a natural approach to healing and recognize there are potential benefits and risks to these techniques as stated below.

Potential Benefits: Relief or resolution of symptoms, reduction of stress, and regulation of imbalances within the body resulting in relief of resolution of main complaint(s).

Potential Risks: Side effects may occur due to acupuncture but are generally mild and/or limited in duration; these can include, but are not limited to, a small amount of bruising or bleeding, mild discomfort, sensations of lightheadedness, or soreness at needle site. Although uncommon, more severe risks include dizziness/fainting, nerve damage, or worsening symptoms. Pneumothorax is a rare risk of acupuncture and is unlikely to occur. There is also a low risk of infection; this is unlikely since your acupuncturist utilizes sterile, disposable, one-time-use needles during treatments and maintains a clean environment. I understand that I will try to avoid large, unnecessary movements during acupuncture treatment in order to minimize these risks. Cupping and gua sha may produce blisters and/or bruise-like appearance on the area of skin the technique is administered. Moxibustion and heat therapy hold the risk of blistering or burning the skin but is uncommon.

Pregnancy: I will notify my acupuncturist prior to treatment if I am, or there is a possibility that I am, pregnant. I understand there are certain points and techniques that have to be avoided during pregnancy because they may include miscarriage or premature labor.

Other: I will notify my acupuncturist if I am at an elevated risk of infection, have a local skin infection; am on anticoagulants or have a bleeding disorder; have a pacemaker.

I have consulted with a physician or dentist (as appropriate) about the condition for which acupuncture treatment is now being sought.

I have been provided with the opportunity to ask questions concerning treatment and the content of this form. I understand this form will cover my treatments for my present condition and any future condition(s) and that my permission will be sought again prior to a new modality being conducted. I understand that I have the right to refuse treatment at any time and understand the consequences of refusal. I consent to having my blood tested in the rarity of a needlestick accident during the course of my treatment.

By signing below, I declare that I understand the above information and give consent to treatment.

Patient/Guardian Signature _____ Date _____

Acupuncturist Signature _____ Date _____