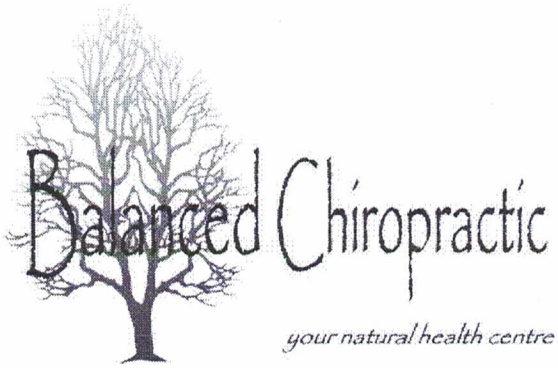

10511 - 100 Avenue
Fort Saskatchewan
Alberta, T8L 1Z5
Phone: (780) 997-0063
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www.balancedchiropractic.ca

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 ☐

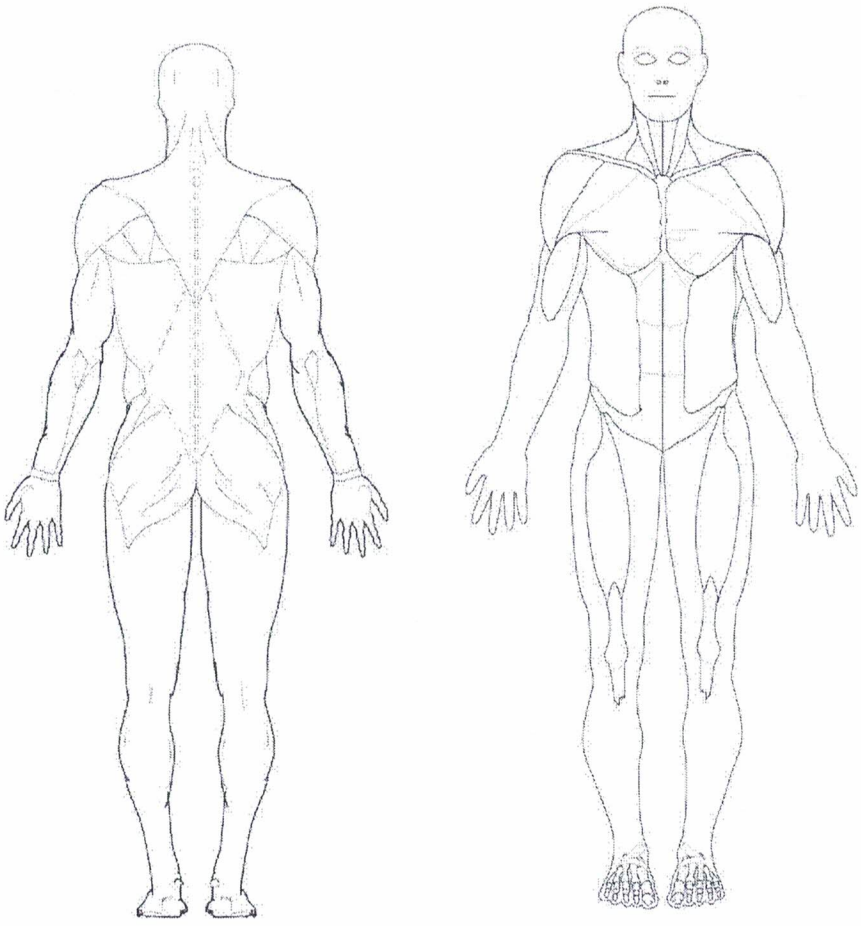
How did you hear about us?		Please write down the name of the person if selected		
Friends / Family	☐		Newspaper / Print Articles :	
Other	☐		Chamber Directory ☐	Fort Sask Guide ☐
Welcome Wagon	☐	Phone Book ☐	Farm and Friends ☐	Sturgeon Creek Post ☐

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

Your Natural Heath Centre

Office Policies

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

Adult	
Initial Exam and Treatment	$125
Chiropractic Treatment	$ 60
Senior (65+)	
Initial Exam and Treatment	$115
Chiropractic Treatment	$ 55
Infant/Child/ Student (0 - 25 years – with Student ID)	
Initial Exam and Treatment	$115
Chiropractic Treatment	$ 55

Cancellation Policy: We require 24 hour notice of cancellation. Failure to due so will result in a $20.00 charge.

Privacy Policy: Information is used to properly identify the individual, acquire x-ray results, order appropriate imaging (xrays, MRI's, CT's, Bone scan's) 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

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