



905.465.4595
2418 Lakeshore Road West
Oakville, ON L6L 1H7

Chiropractic New Patient Form

Patient Information (please print clearly)

Name: Date of Birth: mm/dd/yyyy Age:
Address: City: Postal Code:
Phone: (H) (B) (M)
Email: Occupation:
Where did you find our number? If online, what site referred you?
Emergency Contact: (Name) (Relationship) (Phone number)

Billing Information

Is your complaint related to a motor vehicle accident? Yes No

If Yes, please fill in the following:

Date of accident: Insurer's name:
Claim Number: Insurer's address and telephone number:

Is your complaint a WSIB claim? Yes No

If Yes, please fill in the following:

Employer Name: Social Insurance Number:
Employer address and telephone number:
Date of accident: WSIB Claim Number:

Fee Schedule

Fees are posted at the clinic and online at www.wellnessforthebody.com. They are subject to change without notice.

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. 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 there is a charge of \$20.00 for a second missed appointment. All subsequent missed appointments will then be billed at the regular fee.

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 Wellness for the Body to be a pleasant one and we hope this information will help to make it so.

I have read the Wellness for the Body 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 WELLNESS FOR THE BODY.

Patient Signature: Date:

Patient Name: _____ Date: _____



Health History

Medical Doctor: _____ Phone: _____

Previous Chiropractic care: (Name) _____ (Phone Number) _____

Current Medications (including vitamins and supplements):

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

List any medical problems that other doctors have diagnosed: _____

List other current therapies (ie: physiotherapy, massage): _____

- Exercise level:
- Sedentary (no exercise)
 - Mild exercise (e.g. Climb stairs, walk 3 blocks, golf)
 - Occasional exercise (e.g. work or recreation less than 4x/week for 30 min)
 - Regular vigorous exercise (e.g. work or recreation 4x/week or more for 30 min)

For Women Only:
 Age of onset of menstruation: _____ Date of last menstruation: _____ Length of cycle: _____
 Heavy periods, irregularity, spotting, pain or discharge? Yes No
 Are you pregnant or breast-feeding? Yes No
 Have you had a D&C, hysterectomy, or Cesaerean section? Yes No
 Any urinary tract, bladder, or kidney infections in the past year? Yes No
 Any blood in your urine? Yes No
 Any problems with control or urination? Yes No
 Experienced any recent breast tenderness, lumps, or nipple discharge? Yes No
 Date of last pap smear and rectal exam: _____

For Men Only:
 Do you usually urinate during the night? Yes No If Yes, number of times: _____
 Any blood in your urine? Yes No
 Have you had any kidney, bladder, or prostate infections in the last 12 months? Yes No
 Do you have any problems emptying your bladder completely? Yes No
 Any testicle pain or swelling? Yes No
 Date of last prostate and rectal exam: _____

Other Problems:		
<input type="checkbox"/> Skin <input type="checkbox"/> Head/Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Throat <input type="checkbox"/> Lungs <input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Back <input type="checkbox"/> Intestines <input type="checkbox"/> Bladder <input type="checkbox"/> Bowels <input type="checkbox"/> Circulation <i>Recent Changes in:</i> <input type="checkbox"/> Weight <input type="checkbox"/> Energy level <input type="checkbox"/> Sleep Patterns	<i>Other areas of pain/discomfort:</i>



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Privacy Policy

Privacy of personal information is important to Wellness for the Body. 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 Wellness for the Body can collect, use, and disclose my personal information as set out above in the College's privacy code.

(Signature)

(Print name)

(Date)

(Signature of Witness)

Informed Consent to Chiropractic Treatment

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with treatment. In particular, you should note:

- While rare, some patients have experienced rib fractures or muscle and ligament strains following spinal adjustments
- There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause strokes, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote
- There have been reported cases of disc injuries following cervical and lumbar spinal adjustments, although no scientific study has ever demonstrated such injuries may be caused by spinal adjustments or chiropractic treatments

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than those associated with many medical treatments, medications, and procedures given for the same symptoms.

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) _____

Witness: (print) _____ (Signature) _____

Informed consent to Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, guasha, laser, electroacupuncture, 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 intend 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.

Dated this _____ day of _____, 20_____

Name: (print) _____ (Signature) _____

Witness: (print) _____ (Signature) _____