



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: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (B) \_\_\_\_\_ (M) \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Where did you find our number? \_\_\_\_\_ If online, what site referred you?  Google  MSN  Yahoo  Other

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 Cesaarean 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:
 Skin  Back
 Head/Neck  Intestines
 Eyes  Bladder
 Ears  Bowels
 Nose  Circulation
 Throat
 Lungs
 Chest/Heart
Recent Changes in:
 Weight
 Energy level
 Sleep Patterns
Other areas of pain/discomfort:



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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

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent. I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. 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, as necessary, including moxibustion, cupping, and/or electro acupuncture by the above named doctor or another duly authorized doctor in the clinic. I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Name: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_

Witness: (print) \_\_\_\_\_ (Signature) \_\_\_\_\_