Buzek CHIROPRACTIC CLINIC
41 Princess Street, Leamington, ON
519.322.4859 • www.buzekchiropractic.ca

Welcome To Our Office!

To ensure your visit with us is a pleasant one, here are the procedures you can expect during the next 60 minutes.

PAPERWORK Complete this brief questionnaire and health history to help us get to know you. Dr. Buzek will use this information to help formulate the recommendation for your care.
CONSULTATION You will meet with Dr. Buzek and our Chiropractic Health Technician. Dr. Buzek will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.
EXAMINATION & SPINAL SCANS Standard physical, orthopaedic, neurological and chiropractic tests will be performed to determine the cause(s) of your subluxation. Necessary scans may be performed to visualize the location of any spinal problems, neurological interferences and make your chiropractic care precise.
CORRELATION In order to determine the best course of care for your individual case, the Doctor will study your examination findings. You will see the scans, review your findings and receive specific care and recommendations from Dr. Buzek at your next visit.

CONFIDENTIAL GENERAL PATIENT INFORMATION

Patient #: _____
HIP #: _____ Dx: ___

Date: _____ Primary Care Provider: _____

Name: _____ How would you like to be addressed? _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Occupation: _____ Employed by: _____

Address: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____ Cell/Other: _____

Email _____

Do you give permission for our office to email information/appointment reminders to this address? □ Yes □ No

Marital Status: □ Single □ Married □ Divorced □ Widowed Spouse Name: _____

No. of Children: _____ Name and Ages of Children: _____

Emergency Contact and Phone: _____

Were you referred to our office? □ Yes □ No If yes, by whom? _____

Have you been to a chiropractor before? □ Yes □ No If yes, when were you last adjusted? _____

EXTENDED HEALTH COVERAGE
□ Yes □ No

Primary Insurance Company: _____ Subscriber Name: _____

Patient Relationship to Subscriber: self / spouse / child / other: _____

Policy Number: _____ Id Number: _____

Secondary Insurance Company: _____ Subscriber Name: _____

Patient Relationship to Subscriber: self / spouse / child / other: _____

Policy Number: _____ Id Number: _____

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1. I understand that I am responsible for charges not covered or reimbursed by my extended health plan or similar payer. I agree to pay BCC directly if my benefits plan does not reimburse the provider.
2. I authorize my insurer to release information to BCC regarding my coverage.
3. My right to payment for care, treatments, supplies and other services rendered are hereby assigned to Buzek Chiropractic Clinic. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service rendered. If my insurer does not accept assignment of benefits, or if payments are made directly to me or my representative, I will endorse such payments to Buzek Chiropractic Clinic.
4. I understand and authorize release of all health information about me to my insurer to obtain payment for care, treatment, supplies or other services rendered. The above information is true to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

Thank you. We look forward to a healthy relationship with you!

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New Patient Information:

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: M F

The purpose of this form is to collect information about your current health complaint and to understand your health history. Often times, the source of your complaint stems from another part of your body. Because of this we evaluate your entire body for postural abnormalities and spinal subluxations and measure your nervous system's response to stress. This information helps understand how your body is able to heal/respond to physical, chemical and emotional stressors that you are exposed to daily. Please complete this form in as much detail as possible.

About You:

What is your primary reason/complaint for seeking Chiropractic Care? _____
_____
When did it begin? _____
What do you think caused this? (If a car accident or work-related injury, please inform the front desk) _____
_____
Is it getting worse? □ Yes □ No
What makes it better? _____
What makes it worse? _____
Is the complaint: □ Constant □ Intermittent
Is the complaint worse: □ Morning □ Afternoon □ Evening □ While sleeping
Is the complaint getting: □ Worse □ Better □ Staying the same
Rate the severity of your complaint: (0=no pain / 10=severe pain) 0 1 2 3 4 5 6 7 8 9 10
Do you experience any radiating pain? □ Yes □ No If yes, where? _____
Describe the pain: (check all that apply)
□ Sharp □ Burning □ Dull □ Tingling □ Throbbing □ Cramping
□ Numb □ Swelling □ Shooting □ Pressure □ Ache □ Stiffness
Do you have any other secondary complains? Please list: _____
_____

How does your complaint affect the following aspects of your life:

Length and quality of sleep: _____
Exercise and fitness routine: _____
Work: _____
Family: _____
Social interaction: _____

Past/Current Care Information:

Have you seen a chiropractor before? □ Yes □ No
If yes, who and how long ago? _____
Have you seen any other health care provider for this complaint? □ Yes □ No
List provider name and phone number: _____

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Check off any of the following symptoms you may have experienced in the past six months:

MUSCULO-SKELETAL
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/ Clicking Jaw
- ☐ General Stiffness
- ☐ Knee Pain
- ☐ Ankle/Heel
- ☐ Disc Herniations/Bulging

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL
- ☐ Colitis
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Heartburn
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Poor/Excessive Appetite
- ☐ Gall Bladder Problems
- ☐ Black/Bloody Stool
- ☐ Gas/Bloating After Meals

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

FEMALES ONLY
- ☐ Painful Menstruation
- ☐ Excessive Flow
- ☐ Irregular
- ☐ Cramps or Backache
- ☐ Abnormal Discharge
- ☐ Passed Menopause

Are You Pregnant? Y ☐ N ☐
Birth Control Pill Y ☐ N ☐
Date of Last Cycle_____
No. of Miscarriages _____

GENITO-URINARY
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discoloured Urine

CARDIO-VASCULAR
- ☐ Chest pain/over heart
- ☐ Shortness of breath
- ☐ Blood Pressure Problem
- ☐ Irregular Heart Beat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Congestion
- ☐ Varicose Veins
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Hearing Difficulty
- ☐ Ear Aches/ Infections
- ☐ Stuffed Nose

Have you or anyone in your immediate family experienced:

Cancer:	☐ Self	☐ Mother	☐ Father	☐ Other:	_____
Heart Disease:	☐ Self	☐ Mother	☐ Father	☐ Other:	_____
Arthritis:	☐ Self	☐ Mother	☐ Father	☐ Other:	_____
Scoliosis:	☐ Self	☐ Mother	☐ Father	☐ Other:	_____
Diabetes:	☐ Self	☐ Mother	☐ Father	☐ Other:	_____

Have you experienced any:

Car accidents:	☐ Yes	☐ No	_____
Work related injuries:	☐ Yes	☐ No	_____
Hospitalizations:	☐ Yes	☐ No	_____
Surgeries:	☐ Yes	☐ No	_____

List all medications: _____

_____

List all supplements: _____

_____

List any allergies: _____

_____

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Lifestyle Information:

Please rate your overall health status: Poor 1 2 3 4 5 6 7 8 9 10 Excellent
Will you be healthier 5 years from now than you are today? ☐ Yes ☐ No ☐ Not Sure
Do you smoke cigarettes? ☐ Yes ☐ No
If yes, how long have you smoked and how many per day? _____
Do you drink alcohol? ☐ Yes ☐ No
If yes, how many per week? _____
Do you experience heart burn after meals? ☐ Yes ☐ No
Do you feel energized after meals? ☐ Yes ☐ No
Do you feel overly tired after lunch? ☐ Yes ☐ No
Briefly describe your meals for a typical day:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
How many glasses of water do you drink each day? _____
Do you feel rested when you wake in the morning? ☐ Yes ☐ No
Rate Your Sleep Quality: Poor 1 2 3 4 5 6 7 8 9 10 Excellent
How many hours do you sleep per night: _____
How many times do you exercise per week: _____
How would you rate your overall levels of stress? Low 1 2 3 4 5 6 7 8 9 10 High
At Home: _____ At Work: _____
How do you deal with your stressors: _____
_____
When you wake in the morning, do you feel optimistic about the day? Low 1 2 3 4 5 6 7 8 9 10 High
How many hours a day do you watch television? _____
Do you pray or meditate daily? If so, for how long and where? _____
_____

Additional Information:

Do you have a health care goal/plan? ☐ Yes ☐ No
Are you interested in creating/achieving a plan to reach a health goal? ☐ Yes ☐ No
What do you currently do to prevent illness/disease? _____
_____
Is there anything else about your health history you would like the doctor to know? _____
_____
_____

Authorization and Informed Consent to Evaluate and Care for Individual:

I, _____ do hereby authorize, request an direct the staff and doctors of Buzek Chiropractic Clinic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary. In addition to performing the necessary spinal scans and examinations during your initial visit, the Chiropractor may also scan your feet for custom made orthotics to determine if you may benefit from them. The fee for this scan is included with your New Patient Examination. Chiropractic treatment is one of the safest methods of treating back pain. Still, unexpected problems can occur, such as soreness and stiffness, especially at the beginning of care. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following a neck adjustment is an extremely rare complication, occurring in less than 1 per million treatments. We screen our clients to ensure their safety and refer out to supporting providers when necessary.

Patient Signature: _____ Date: _____