Buzek CHIROPRACTIC
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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Young Adult Information Form (13-17 Years)

Patient Information:

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: □ Male □ Female
Parent(s) Name: _____

Current Health Concern

What is the primary reason that you are seeking Chiropractic care for your child?

_____
When did this problem begin? _____
Is it getting worse? □ Yes □ No
Is this problem: (circle) occasional frequent constant intermittent
Does problem radiate? □ Yes □ No If Yes, where? _____
_____
What makes this worse? _____
What makes this better? _____
Is the problem worse during a certain time of the day? □ Yes □ No
If Yes, when? _____
Does this interfere with the your daily activites? How? _____
_____

Child Health History

Place of birth: □ Home □ Birthing Center □ Hospital
Provider: □ Midwife □ OB-Gyn □ Other
Type of Birth: □ Vaginal □ Cesarean
List any food or environmental allergies: _____
_____
Does your child have regular bowel movements? □ Yes □ No
Current Weight: _____ Current Height: _____
List any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:
Include year: _____
_____
List any hospitalizations or surgeries your child has experienced including year: _____
_____
Has your child ever been checked for vertebral subluxations? □ Yes □ No

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Are there any of the following symptoms present?

Stomach pains	Allergies	Repeated Colds
Hyperactivity/Autism	Growing Pains	Digestion
Leg/Knee pains	Headaches/Migraines	General Fatigue
Scoliosis	Seizures	Acne/Skin problems
Learning Difficulties	Infections	Depression
Low Energy	Tonsillitis	Menstrual cramps
Asthma	Diarrhea	Anxiety
Irritability/Moodiness	Constipation	Excessive hunger
Low self-esteem	Sleeping Problems	

Other: _____

Chemical Stressors

Has your child been vaccinated? □ Yes □ No
Did your child have any reactions to these vaccines? □ Yes □ No
Has your child been on antibiotics? □ Yes □ No
If yes, how often and for what purpose? _____
Is your child currently taking any medicatons? □ Yes □ No If yes, please list: _____

_____

Is your child currently taking any vitamins? □ Yes □ No
If yes, please list: _____
How many glasses does your child drink per day? Water _____ Milk_____Juice _____ Soda_____
Does your child consume artificial sweeteners? □ Yes □ No
Rate your child's diet: □ Well-balanced □ Average □ High sugar/processed food
What is your child's favourite food? _____

Is there anything else the Doctor should know? _____

_____

Have you, the child's legal guardian, had any personal experience with Chiropractic? □ Yes □ No

_____

Authorization to Evaluate and Care for a Minor

I, _____, the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request, and direct the staff and doctors of Buzek Chiropractic Clinic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's Name: _____

Parent/Guardian's Signature: _____ Date: _____