**CLAYTON PARK CHIROPRACTIC CENTRE INC.**
Suite 11-117 Kearney Lake Road
Halifax, Nova Scotia
B3M 4N9
(902) 443-5669 phone
(902) 443-9419 fax
info@claytonparkchiro.ca

Bilaterals (For Office Use Only) L+___ R+___

## PERSONAL INFORMATION

Full Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home Phone# _____ Work Phone# _____
Can we leave a message at this number? □ Yes □ No — Can we leave a message at this number? □ Yes □ No

Cell Phone# _____ Email Address: _____
Can we leave a message at this number? □ Yes □ No — Can we send you our monthly e-news letter? □ Yes □ No

Date of Birth: ___/___/___ Age: ____ Sex: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No
**mm/dd/yy**

Marital Status: **(circle)** Married Single Widowed Divorced Separated Other No. of Children: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone# _____ Relationship: _____

**Who may we thank for referring you to this office?** _____

Do you have insurance that covers Chiropractic care? ☐ Yes ☐ No

*****Please let the front desk know if you require a BLUE CROSS CLAIM form*****

## ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "**General Health History**".

### HEALTH CONCERNS

| Please list your health concerns according to their severity | Rate of severity 0 = no pain 10 = worst imaginable | When did this episode start? | Did this problem begin with an injury? | If you had this condition before, when? | % of the time pain is present | Does the pain radiate? If so, where? | Is the problem: -about the same -Getting better -Getting Worse |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |

Which activities aggravate your condition? _____

What have you done for this condition? Was it of benefit? _____

I do (do not) have a family history of this or similar symptoms (Please explain):_____

I do (do not) have a family history of heart disease, diabetes, cancer or arthritis (Please explain):_____

**Other practitioners you have seen for this condition:**

☐ Pain or Wellness Chiropractor Name: _____

☐ Medical Doctor Name: _____

☐ Dentist Name: _____

☐ Personal Trainer Name: _____

☐ Naturopath Name: _____

☐ Physiotherapist Name: _____

☐ RMT Name: _____

Please check the following box if we have permission to provide support of our findings to the above practitioners ☐

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what? _____

_____

_____

Is this condition interfering with any of the following?

Work ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Other ☐ (please explain): _____

If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

On a scale of 1-10, (10 being the highest) rate your level of commitment to correcting this problem: _____

## GENERAL HEALTH HISTORY

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this, as it will help us help you!

Have you had any surgery? (Please include all)

| | | |
|---|---|---|
| 1. Type: | When? | Doctor |
| 2. Type: | When? | Doctor |
| 3. Type: | When? | Doctor |

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems)

| | | |
|---|---|---|
| 1. Type: | When? | Hospitalized? ☐ Yes ☐ No |
| 2. Type: | When? | Hospitalized? ☐ Yes ☐ No |
| 3. Type: | When? | Hospitalized? ☐ Yes ☐ No |

Have you ever had x-rays taken? ☐ Yes ☐ No

| | | |
|---|---|---|
| Area of body: | When? | Where? |

Do you wear orthotics or heel lifts? ☐ Yes ☐ No

## CURRENT MEDICINES AND SUPPLEMENTS

Please list any medications/drugs you have taken in the past 6 months and why? (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why? _____

_____

_____

## PAST HEALTH HISTORY

Please mark the following conditions you may **HAVE HAD** or **HAVE NOW** ( **- have had** / **+ have now**)

**Nervous System**
□ Nervousness
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion / Depression
□ Fainting
□ Convulsions
□ Cold / Tingling Extremities
□ Stress

**Musculo-Skeletal**
□ Arthritis
□ Low Back Pain
□ Gas/Bloating After Meals
□ Pain Between Shoulders
□ Heartburn
□ Neck Pain
□ Black/Bloody Stool
□ Arm Pain
□ Colitis
□ Joint Pain / Stiffness
□ Walking Problems
□ Difficult Chewing / Clicking Jaw
□ General Stiffness

**General**
□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

**C-V-R**
□ Chest Pain
□ Short Breath
□ Arteriosclerosis
□ High / Low Blood Pressure
□ Irregular Heartbeat
□ Heart Problems
□ Lung Problems / Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke
□ Asthma

**EENT**
□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty
□ Stuffed Nose
□ Sinus Problems

**Gastro-Intestinal**
□ Poor / Excessive Appetite
□ Excessive Thirst
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Weight Trouble
□ Abdominal Cramps

**Male / Female**
□ Menstrual Irregularity
□ Menstrual Cramping
□ Vaginal Pain / Infections
□ Breast Pain / Lumps
□ Prostate / Sexual Dysfunction

**Genito-Urinary**
□ Bladder Trouble
□ Painful / Excessive Urination
□ Discoloured Urine

**Other**
□ Depression
□ Gout
□ Measles
□ Pleurisy
□ Ulcers
□ Alcoholism
□ Diabetes
□ Heart Attack
□ Miscarriage
□ Pneumonia
□ Thyroid Problems
□ Anemia
□ Eczema
□ HIV (Aids)
□ Multiple Sclerosis
□ Polio
□ Venereal Disease
□ Cancer
□ Emphysema
□ Low Blood Sugar
□ Mumps
□ Rheumatic Fever
□ Whooping Cough
□ Cold Sores
□ Epilepsy
□ Malaria
□ Neuritis
□ Tuberculosis

Do you have a pacemaker? □ Yes □ No _____
Do you have a bleeding disorder? □ Yes □ No _____

Other (please explain): _____

_____

## STRESSORS (this section is VERY IMPORTANT and MUST be completed)

Because accumulation of stress affects our health and ability to heal please **list your top three stresses** (you have ever had) **in each category:**

1. **Physical stress** (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. **Bio-chemical stress** (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. **Psychological or mental/emotional stress** (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a **scale of 1-10** please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

| At work: | At home: | At play: |
|---|---|---|

On a **scale of 1-10**, (1 being very poor and 10 being excellent) please describe your:

| Eating Habits: | Exercise habits: | Sleep: | General Health: | Mind set: |
|---|---|---|---|---|

How do you grade your physical health?

| Excellent ☐ | Good ☐ | Fair ☐ | Poor ☐ | Getting better ☐ | Getting worse ☐ |
|---|---|---|---|---|---|

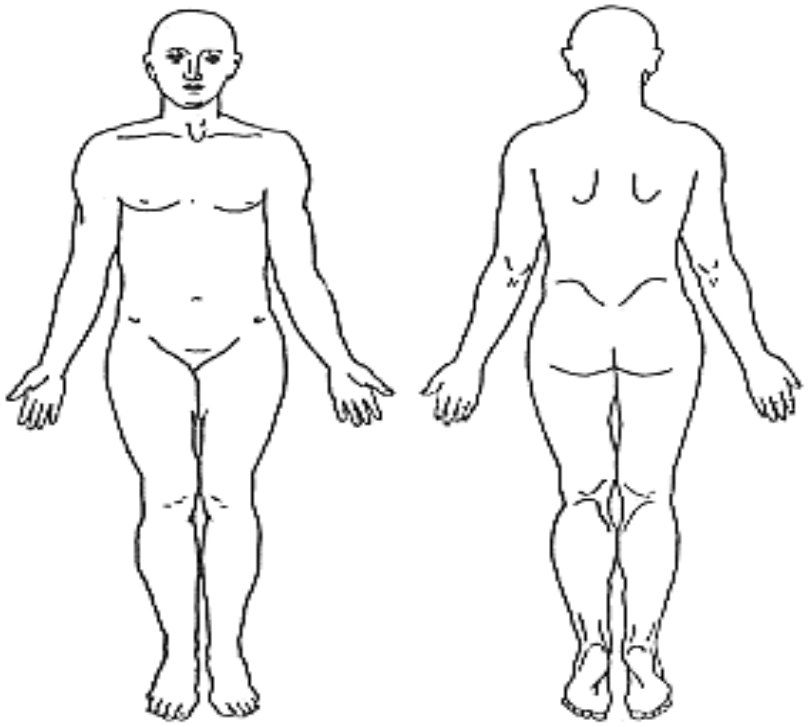
How do you grade your emotional/mental health?

| Excellent ☐ | Good ☐ | Fair ☐ | Poor ☐ | Getting better ☐ | Getting worse ☐ |
|---|---|---|---|---|---|

**INDICATE AREAS OF PAIN (OR) DISCOMFORT:**

**In the diagrams below, please mark the areas on your body, which you feel best represents the pain(s) or sensation(s) that you experience. Please include all areas.**
Use the symbols provided below**.**

| | | | |
|---|---|---|---|
| **Numbness** | ≡ | **Pins & Needles** | * * * * * * |
| **Burning** | XXX XXX | **Sharp & Stabbing** | / / / / / / |
| **Dull & Aching** | + + + + + + | **Stiff & Tight** | 2 2 2 2 2 2 |



Is there anything else which may help to better understand you, which has not been discussed? _____

_____

_____

_____

Why are you here at this point in time? _____

_____

_____

**OFFICE FEE SCHEDULE & FINANCIAL POLICY**
(Chiropractic prices are *not* subject to tax)

**CHIROPRACTIC SERVICES:**

| | |
|---|---|
| Consultation | *NO CHARGE* |
| Initial Chiro Exam (with Scans) | $85.00 |
| Chiro Adjustment | $55.00 |
| Chiro Adjustment (Child) | $45.00 |
| Chiro Re-Assessment | $65.00 |
| Chiro Re-Assesment (Child) | $55.00 |
| Diagnostic Spinal Scan / Re-Scan | $30.00 |
| Chiro Extended Visit (Chiro & Acupuncture Session) | $85.00 |
| **Missed Appointment Charge** | **$45.00** |

**FINANCIAL POLICY AND CHIROPRACTIC ACTIVE LIFE PLANS**
We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designated to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Report of Findings appointment.

| **REGISTERED MASSAGE THERAPY SERVICES:** | **MICHELLE HOLMES, RMT**<br>(Osteopathic practitioner in study) |
|---|---|
| ½ HOUR SESSION (specific area) | $53.92 (plus tax) |
| 1 HOUR SESSION | $78.26 (plus tax) |
| 1 ½ HOUR SESSION | $128.70 (plus tax) |
| 2 HOUR SESSION | $154.79 (plus tax) |

## If less than 24 hours notice to cancel Massage Therapy appointments is given a FULL FEE will be charged.

**NO DIRECT BILLING** – Our office does NOT direct bill to any insurance company therefore **PAYMENT IN FULL IS DUE** on date of service.

We accept exact cash, debit or credit cards. (Visa & Mastercard only)

This office is **SCENT SENSITIVE.** Please refrain from wearing strong perfumes and aftershaves during your visit.

I, (printed name) _____ have read and I understand the above policies. I have indicated the receipt option that applies to me.

_____ _____
**Patient signature** (or guardian) **Date**