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New Patient Intake Form

Patient Name: _____ Date: _____
Gender: M F Birthdate: (mm/dd/yyyy) _____ Age: _____
Marital Status: _____ Spouse Name: _____ Children's Name(s): _____
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell: _____ Work: _____
Email Address: _____
Occupation: _____ Company: _____
Emergency Contact: _____ Phone: _____
Do you have extended healthcare? Yes No If yes, with who? _____
Who is your Medical Doctor? _____
Other Healthcare Practitioners? _____
Who is your Massage Therapist? _____

Referrals are our highest compliment. Please share with us where you heard about our office:

How did you hear about us? Friend/Family Brochure/ Workshop Facebook
 Google Search RateMD Other _____

If you were referred by someone please specify (name): _____

Have you had previous chiropractic care? Yes No Date of last visit? _____

Initial

Record Transfer Authorization: I consent to the release of my information to his/her family doctor and other health practitioner listed above for the purpose of inter-professional collaboration. As a courtesy and to improve quality of care you may send a medical report to my health care providers.

Consent to Examination:

Today's appointment will include a consultation and examination. The purpose of this examination is to determine the cause of any health problems you may be experiencing. The exam may include a postural assessment, range of motion testing, orthopedic, neurological test and a chiropractic spinal exam. Your chiropractor will then determine the best course of treatment for your individual case.

Signature: _____ Date: _____

What is your reason for consulting Price Chiropractic & Fitness (please check):

- ____ I have a specific problem and only require help with this problem
____ After my problem has been relieved I want to ensure the problem does not return
____ I have no symptoms of complaints. I am here for a wellness checkup.

Patient Name: _____

Chart #: _____

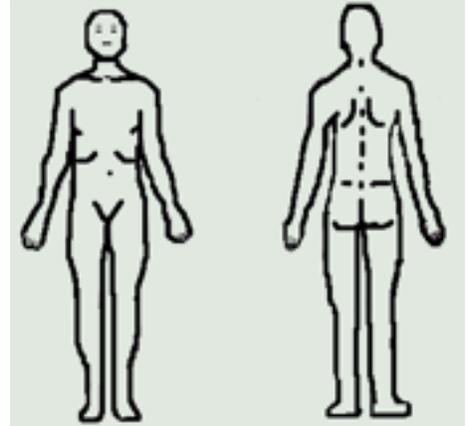
Doctor: _____

How can we help you?

Please mark on the diagram where you feel pain

What are your main health concerns?

Are there any other areas of concern in your body?



When did this problem begin? _____

Has this problem occurred before? Yes No

How often does it happen? _____

Please place an X on the grade indicating the severity of your pain

(Least) 1 2 3 4 5 6 7 8 9 10 (Worst)

How would you describe the pain?

- Dull Ache Sharp Stabbing Tight
- Stiff Throbbing Burn Numb Tingle

Does the pain spread to other areas: Yes No

If yes, where? _____

What makes it worse? Sitting Standing Lying Down Bending Twisting
 Lifting Activity Walking Other: _____

What makes it feel better? Rest Lying Down Ice Stretching
 Massage Changing Position Medication Heat

Does this problem interfere with:?
 Ability to work Enjoyment of family or social time
 Ability to enjoy hobbies or sports

Have you seen someone else for this concern? Yes No Who? _____

Type of treatment: _____ Results: _____

Are there other areas of concern you would like to discuss with the doctor or therapist? _____



CHIROPRACTIC & FITNESS

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Consent to Chiropractic Treatment

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustments and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise

Benefits:

Chiropractic treatments has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks:

Temporary worsening of symptoms - Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

Skin irritation or burn - Skin irritation or burn may occur in association with use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

Sprain or strain - Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

Rib fracture - While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

Injury or aggravation of a disc - Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage may occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may not know they have a problem. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Stroke - Arteries in your neck may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and traveling up to the brain.

Chiropractic treatment has also be associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function as well as a paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professional. Your chiropractor may also prescribe rest without treatment, or exercises with or without treatment.

Questions or concerns

you are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Printed Name

Signature of Patient / Guardian

Date

Signature of Chiropractor:

Date: