Dr. Ed Lubberdink
Dr. Tonya Luby
Dr. Stacey Smith
Dr. Amanda Graham
Family Wellness Chiropractors

Bayview Village Wellness Centre
2901 Bayview Ave
Professional Offices Suite 201
Toronto, ON M2K 1E6
416 221 7724

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: (_____) _____ Birth date: _____/_____/_____(mm/dd/yy) Sex: ❑ M ❑ F
Occupation: _____ Business / Employer: _____
Business Phone: (_____) _____ Extended Health Coverage: _____
Marital Status (Please check one): ❑Married ❑Single ❑ Widowed ❑ Divorced ❑ Separated ❑ Other No. of Children: _____
Mobile Phone: (_____) _____ Name of Emergency Contact: _____
Emergency Contact's Relationship: _____ Phone Number For Emergency Contact: (_____) _____
Referred To This Office By: ❑ Yellow Pages ❑ Website ❑ RMT ❑ Patient/Dr. (name): _____
Email Address: _____How will you be taking care of your account? ❑ Cash ❑ Visa/MC❑Interac

WHY THIS FORM ISIMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Research is showing that most health challenges that occur later in life have their origins during the developmental years, some starting at birth.
If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) here _____ and skip to "**Past Health History**". Those who have symptoms or complaints need to continue filling out the section below, "**Current Health Conditions**".

CURRENT HEALTH CONDITIONS

Current Complaint(s): _____
Other Doctors seen for this condition?❑ Yes ❑ No If yes, Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ❑ Yes ❑ No
What aggravates your condition? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting ❑ Walking ❑ Lying Down
❑ Cold ❑ Dampness ❑ Other: _____
What relieves your condition? ❑ Bed Rest ❑ Ice ❑ Heat ❑ Massage ❑ Medication
❑ Other: _____
Is it getting: ❑ Worse ❑ Constant ❑ Better ❑ Comes and Goes
Character of Pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Numb ❑ Burning ❑ Pins and Needles
Please describe the problem at its worst: _____
_____
When the problem is at its worst does it interfere with:
Your ability to work?_____
Your ability to enjoy family / social time?_____
Your ability to enjoy sports or hobbies?_____
If it isn't corrected, do you think this will get worse over the next 5 years? ❑ Yes ❑ No
Drugs you now take: ❑ Nerve Pills ❑ Insulin ❑ Pain Killers ❑ Muscle Relaxant ❑ Blood Pressure Medication
❑ Others: _____
Do you suffer from any other condition(s) other than that for which you are now consulting us? ❑Yes ❑No
If yes, describe: _____
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____
Have you had x-rays taken in the last 6 months? ❑ Yes ❑ No If yes, where? _____

PAST HEALTH HISTORY

Major Surgery / Operations: ❑ Appendectomy ❑ Broken Bones ❑Gall Bladder ❑ Tonsillectomy ❑ Hernia ❑Other:_____
Major Accidents or Falls: _____
Hospitalization /Infectious Diseases(other than for above): _____
Previous Chiropractic Care: ❑ None ❑ Doctor's name and approximate date of last visit: _____

FAMILY HEALTH HISTORY

Does any family member suffer from this same condition? ❑ Yes ❑No Whom? _____
Have your children ever had a spinal check up? ❑ Yes ❑No If yes, where and when? _____

_____

Please check off **ALL** of the following you have EVER had even if you don't think they are related to your current problem:

- ❑ Low Back Pain
- ❑ Gas/Bloating/Heart Burn
- ❑ Neck/Arm/Shoulder Pain
- ❑ Colitis/Irritable Bowel Syndrome
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness
- ❑ Nervous/Stress
- ❑ Dizziness
- ❑ Confusion/Depression/Forgetful
- ❑ Fainting/Convulsions
- ❑ Cold/Tingling/Numbness
- ❑ Chest Pain/Shortness of Breath
- ❑ Blood Pressure Problems
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins/Ankle Swelling
- ❑ Stroke
- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches
- ❑ Vision Problems
- ❑ Sore Throat/Ear Aches
- ❑ Stuffed Nose
- ❑ Frequent Nausea/Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Liver/Gall Bladder Problem
- ❑ Abdominal Cramps
- ❑ Menstrual Irregularity/Cramping
- ❑ Miscarriage(s)
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction
- ❑ Cancer

FEMALES

When was your last period?

_____

Are you pregnant?
❑ Yes ❑No ❑ Not sure ❑ Trying

INTAKE

- ❑ Coffee
- ❑ Tea
- ❑ Alcohol
- ❑ Cigarettes
- ❑ White Sugar

PERSONAL SATISFACTION WITH DIET

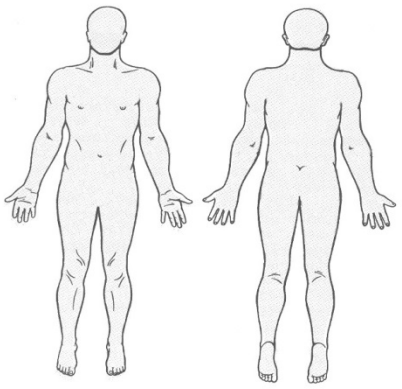
- ❑ Highly Satisfied
- ❑ Somewhat Satisfied
- ❑ Dissatisfied

DO YOU HAVE A REGULAR EXERCISE PROGRAM?

- ❑ Yes ❑No

LIFESTYLE STRESS LEVEL

- ❑ High
- ❑ Moderate
- ❑ Low



Please outline on the diagram, the area of your discomfort and any radiation of pain

EMOTIONAL STRESSORS

Career_____
Relationships_____
Money_____
Children_____
Work/Life Balance_____
Loss of Loved One_____

PHYSICAL STRESSORS

Car Accidents_____
Sport Injuries_____
Poor Posture_____
Excessive Desk Work_____
Slips/Falls_____
Birth Traumas_____

CHEMICAL STRESSORS

Smoking_____
Processed Food_____
Medications_____
Antibiotics_____
Sugar/Artificial Sweeteners_____
Work with Chemicals_____

***The purpose of* our chiropractic care is to support and empower you in achieving your optimum health and to educate you so that you may understand your health and chiropractic.**

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Please read carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Bayview Village Wellness Centre will prepare any necessary forms and reports to assist me in making collection from the insurance. Any amount authorized to be paid directly to Bayview Village Wellness Centre will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

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;

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_____.

_____
Patient Signature (Legal Guardian)

Name:_____
(please print)

_____
Witness of Signature

Name:_____
(please print)

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OFFICE POLICY

To our patients:

Thank you for seeking Chiropractic care as a method to evaluate your conditions and to restore your health *naturally*. Shortly you will be interviewed by the Doctor. After reviewing your completed, confidential health questionnaire, should the Doctor feel your conditions would best be treated by another health practitioner, you will be advised and referred accordingly. However, should your condition fall within the scope of Chiropractic, a thorough consultation will be undertaken to document your case history. A comprehensive Chiropractic examination will then be conducted to determine the *cause* of your problem(s). The examination consists of:

- *Postural Analysis*
- *Physical Examination*
- *Orthopaedic/Neurological Examination*
- *Radiology*

After this initial session, examination findings will be interpreted. During your second visit, the Doctor will explain the findings and will make recommendations for the Chiropractic care required in your particular case.

Please note: In order to achieve the maximum benefit from your Chiropractic care, it is necessary to follow the care plan outlined by your Doctor.

FEE SCHEDULE

Procedure	Patient Fee
New Patient Consultation and Examination	99.00
New Patient X-Rays	included
Progress Exam	30.00
Computerized Muscle Testing	25.00
Adjustments – Adult	45.00
Adjustments – Children	30.00
Re-Examination and X-Rays	114.00

Fees are due when services are rendered. There will be a charge of $5.00 for each missed appointment unless 6 hours notice is given.

I have read and understood the above, and will be bound to the terms and conditions outlined.

_____ _____ _____

(Print name) (Signature) (Date)

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CONSENT FOR XRAYS

Dr. Ed Lubberdink
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Dr. Stacey Smith
Dr. Amanda Graham

Doctors of Chiropractic

For Women

This is to certify, to the best of my knowledge, that I am not pregnant and the Bayview Village Wellness Centre has my permission to take x-rays.

_____ _____ _____
(Print name) (Signature) (Date)

I am presently using:

Birth Control Pills _____

IUD _____

Within 10 days of my period _____

Or

I will assume responsibility for any effect on a fetus potentially present for one of the following:

Hysterectomy _____

Tubal Ligation _____

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EMAIL CONSENT

Canada's new anti-spam legislation (CASL) has taken effect on July 1st, 2014. In an effort to be in compliance with CASL, Bayview Village Wellness is requesting your consent to send you valuable updated health care news and information VIA EMAIL. There may also be times when your doctor or the office needs to contact you. Please fill out the information below; this allows us to email you with office announcements and health topics of interest to you.

I _____, give my consent to receive emails
(Please Print)

from The Bayview Village Wellness Centre.

_____ _____

Signature Date