Females Only

When was your last period?

_____

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

- ☐ Yes
- ☐ No

If yes, where? _____

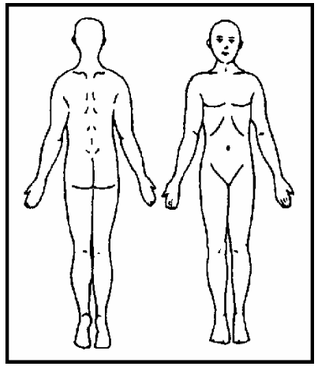
Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema

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



Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Preventative Care – Life Enhancement and Wellness Care
- ☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
- ☐ Relief Care – Band-Aid Care Only
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

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 the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

I hereby request and consent to the performance of assessments, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, laser therapy and other procedures, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. When used in combination with certain medications laser therapy can cause burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. I also understand that the laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

_____ _____

Patient Signature Date

St. Catharines Chiropractic & Heath Centre 320 Vine Street St. Catharines, Ontario L2M 4T3

Welcome To Our Office

Outline of Procedures for New Patients:

Step 1

All new patients are requested to fill out a confidential **"Patient Health Record"**.

Step 2

Your first **"Consultation"** with the doctor to discuss your health problems.

Step 3

You will receive a **"Chiropractic Examination"** to determine if chiropractic care is appropriate for your condition.

Step 4

An in-depth, technologically-advanced assessment of your nerve and energy system to determine how well your brain is communicating with your body. Any interference to this communication may be measured by **surface electromyography** which studies **muscle function**, **dermothermography** which illustrates **inflammation** and **autonomic nervous system function**, and a **health status questionnaire** will provide an in-depth analysis of how your condition is affecting your health and life. As well, if indicated, **x-rays** will be taken to visualize the location of spinal problems, a **computerized gait analysis** to study effects on posture and/or a **BioPrint/PosturePrint analysis** to study your actual posture.

Step 5

If your case requires immediate attention, **first day Chiropractic procedures** will be administered.

Step 6

You will be advised as to a time you can return for **a "New Practice Member Orientation"** (N.P.M.O.) with the doctor / staff. Our records show that those patients who respond most rapidly to care are those who have learned to help themselves. We give you, your family and friends the opportunity to learn what you can do to help us return you to health more quickly and cost effectively, and what one needs to do to stay healthy.

Step 7

You will be advised as to a time you can return for your **"Report of Findings"** when your doctor will inform you as to your examination results and whether or not your case has been accepted. If accepted your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step 8

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the **maximum possible improvement has been obtained.**

Step 9

Website Membership Enrollment: The information on our website will help you Get Well and Stay Well. Please provide your email address so we can establish you as a member of our website today. Please check the health subjects that most interest you:

☐ Headaches and Neck Pain ☐ Backaches and Sciatica ☐ Children's Health Issues ☐ Exercise and Fitness
☐ Diet and Nutrition ☐ Stress Management ☐ Women's Health Issues ☐ Wellness Topics

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt out at any time. Please review our complete privacy policy on our website.

☐ I would like to receive newsletters by e-mail Email Address _____

To save time and allow us to better serve you, please complete all questions on the next pages. Thank you!

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Birthdate: DD / MM / YYYY Age: ____ Sex: ☐ M ☐ F
Cell Phone: _____
Business/Employer: _____ Business Phone: _____
Type of Work: _____
Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
How were you referred to this office? ☐ Yellow Pages ☐ Website ☐ Friend/Family Member ☐ Physician
Who may we thank for referring you to this office? _____
How will you be paying your account? ☐ Visa ☐ Mastercard ☐ Cash ☐ Cheque ☐ Interac ☐ Other

Current Health Condition

Current Complaint(s): _____
Other doctors seen for this condition? ☐ Yes ☐ No Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: _____
Date of Accident: _____ Time of Accident: _____
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 ☐ Comes/Goes ☐ Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent
Please describe how it feels when this problem is at its worst: _____
_____
Place an X on the grade to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:
Your ability to work? _____
Your ability to enjoy your family or your social time? _____
Your ability to enjoy your hobbies or sports? _____
At its worst, how old does this problem make you feel? _____
If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Name all medications if known: _____
_____
Do you suffer from any other condition than the one you are now consulting us for? _____
_____
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 six months? ☐ Yes ☐ No If yes, where? _____

St. Catharines Chiropractic & Heath Centre 320 Vine Street St. Catharines, Ontario L2M 4T3

Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: _____
Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injuries ☐ _____
Hospitalization (other than above): _____
_____
Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____
Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____ ☐ I do not have a Family Physician ☐ I attend walk-in clinics
Please indicate any health issues that are present in your family:
Parents: _____
Siblings: _____
Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____
Have your children ever had a spinal check-up? ☐ No ☐ Yes ☐ If yes, where and when? _____
_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past six months:

Nervous System
☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion / Depression
☐ Fainting
☐ Convulsions
☐ Cold / Tingling Extremities
☐ Stress

Musculo-Skeletal
☐ 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
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

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

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
☐ Discolored Urine