



Why this form is important – As a family wellness-oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate & eliminate any & all interference to the full outward expression of that potential & address the issues that brought you here. Most times, the effects are so gradual that they are not felt until they become serious, & sometimes not until it's too late! In addition, we hope to offer you & your family the opportunity for a **lifetime** of health, happiness & vitality.

Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status & more accurately determine what course of care will best help you reach your true health potential.

PERSONAL AND FAMILY HEALTH HISTORY

Today's Date: _____

Name: _____ Date of Birth (mm/dd/yyyy): _____ (Age _____)

Address: _____ Sex: F M BC Health Card #: _____

City: _____ Prov.: _____ Postal: _____ Are you or might you be pregnant? Yes No

Phone: (H) _____ (W) _____ Occupation: _____

Email: _____ Employer: _____

Referred by: _____ Spouse's Name: _____

Names of children (ages): _____

GROWTH & DEVELOPMENT

Did you ever...

Have any serious falls or accidents? Y / N _____

Have recurrent childhood illness/sickness? Y / N _____

Experience other serious traumas/stress? Y / N _____

CURRENT HEALTH HABITS

Do you...

Eat healthy foods regularly? Y / N _____

Drink 8-10 cups of water daily? Y / N _____

Exercise regularly? Y / N _____

Smoke? Y / N _____

Have high mental stress? Y / N _____

Have high physical stress? Y / N _____

Have any serious or chronic past injuries? Y / N _____

Have sleeping problems? Y / N _____

Sleeping position: side; stomach; back _____

Have you been in car accidents? Y / N _____ When? _____

Was Your Birth Traumatic?

(Circle if you know...)

Long delivery?..... Y / N

Difficult delivery? Y / N

Forceps/vacuum extractor?.. Y / N

Caesarian section?..... Y / N

Breech/cephalic?..... Y / N

Mother given drugs/
epidural during birth?..... Y / N

Induced labour?..... Y / N

FAMILY HEALTH PROFILE – Please mark if you have a family history of:

	Arthritis	Cancer	Diabetes	Heart Disease	High Blood Pressure	Strokes	Other _____
Your father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Your mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Your children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICAL INFO: Who is your medical doctor? _____

If you are taking medications, please list them.

Med: _____ For what? _____ For how long? _____

Med: _____ For what? _____ For how long? _____

Med: _____ For what? _____ For how long? _____

Other: _____

What side effects have you experienced from the drugs &/or surgery?

If you have had any surgeries, please list them.

Surgery: _____ For what? _____ Date: _____

Surgery: _____ For what? _____ Date: _____

Surgery: _____ For what? _____ Date: _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Have you been to a chiropractor before? Y / N If yes, who have you seen? _____
 If yes, for what? _____ When was your last adjustment? _____

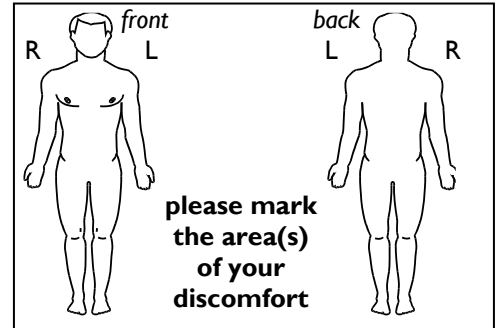
*** If you have no symptoms or complaints and you are here for wellness care, please check here:
 I wish to have Chiropractic Wellness Services
 & skip to the **CURRENT SYMPTOMS** section near the bottom of this form. Otherwise, please continue.

Present Complaint (Reason for your visit today):

Pain or problem started how and when? _____

What activities make your condition / pain worse? _____

What activities make your condition / pain better? _____



If you have pain, is it... sharp dull radiating constant intermittent
 mild moderate mod-severe severe

Since it began, is it... the same variable getting better getting worse

What time of day is worst? waking at work evening
 at night variable constant

Does it interfere with... work sleep walking
 sitting exercise other _____

Are there other doctors / treatments that you have tried for this problem? (Please list.)

massage therapist _____ physiotherapist _____
 acupuncturist _____ medical doctor _____
 other _____

OTHER TESTS: (please circle)

Have you ever had:
 X-rays / CT scan / MRI
 of your :
 Neck / Back / Hips/pelvis

If yes, how long ago?
 <7 years, > 7yrs

Do you remember what the
 results were? _____

CURRENT SYMPTOMS (even if they do not seem related to your current condition):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> dizziness / vertigo | <input type="checkbox"/> sinus problems / allergies | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> neck stiffness / pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heart problems / stroke |
| <input type="checkbox"/> shoulder stiffness / pain | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> constipation / diarrhea | <input type="checkbox"/> cancer |
| <input type="checkbox"/> pins & needles in arms | <input type="checkbox"/> tension / stress | <input type="checkbox"/> problems urinating | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> nervousness / anxiety | <input type="checkbox"/> cold sweats | <input type="checkbox"/> recurring infection |
| <input type="checkbox"/> back stiffness / pain | <input type="checkbox"/> irritability / mood swings | <input type="checkbox"/> hot flashes | <input type="checkbox"/> loss of smell / taste |
| <input type="checkbox"/> pins & needles in legs | <input type="checkbox"/> depression | <input type="checkbox"/> menopause | <input type="checkbox"/> vision changes |
| <input type="checkbox"/> numbness in feet / toes | <input type="checkbox"/> stomach upset | <input type="checkbox"/> PMS / menstrual cramps | <input type="checkbox"/> buzzing / ringing in ears |
| <input type="checkbox"/> foot problems | <input type="checkbox"/> heartburn / reflux | <input type="checkbox"/> infertility / impotence | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> jaw / TMJ problems | <input type="checkbox"/> ulcers | <input type="checkbox"/> cold hands / feet | <input type="checkbox"/> chest pains |
| <input type="checkbox"/> other _____ | | | |

RESULTS:

As a result of my chiropractic care, I would like to: (Please check all that apply)

- Feel better quickly* *Live a healthier lifestyle*
 Have a healthier spine *Learn about a healthier lifestyle*
 Have a healthier body by keeping my nerve system healthy

 Signature

 Date

On a daily basis, we all experience physical, chemical, & emotional stresses that can accumulate & result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, & sometimes not until it is too late!
 At **PITT MEADOWS WELLNESS CENTRE**, we will help to find & treat the cause of these effects.
Chiropractic helps your entire body – for a healthier life & spine!

PITT MEADOWS WELLNESS CENTRE



...experience life!

OFFICE FEE SCHEDULE & FINANCIAL POLICY

(fees subject to change with 30 days posted notice)

◆ Consultation	No Charge	◆ Chiropractic Adjustment	\$45
◆ Initial Examination	\$70	Children 18 & under	\$35
◆ Progressive Examination	\$45	◆ Family Care Plan.....	on individual basis
		◆ Wellness Care Plan	on individual basis

WE ARE COMMITTED TO PROVIDING YOU THE BEST CHIROPRACTIC CARE POSSIBLE IN A CARING ENVIRONMENT & 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.

AUTOMOBILE COLLISION OR WORK INJURY

IF YOUR HEALTH PROBLEM IS THE RESULT OF A MOTOR VEHICLE ACCIDENT OR IF IT IS A WORK INJURY, PLEASE NOTIFY OUR OFFICE MANAGER. IF WE ACCEPT YOUR CASE, WE MUST RECEIVE APPROVAL FROM ICBC OR WCB FOR CHIROPRACTIC ADJUSTMENTS. UNTIL THAT TIME, YOU WILL BE EXPECTED TO PAY IN FULL FOR YOUR CHIROPRACTIC CARE AT THE TIME THE SERVICE IS RENDERED. UPON APPROVAL, YOU WILL BE REFUNDED ANY EXTRA MONIES PAID.

HEALTH INSURANCE

THE MEDICAL SERVICES PLAN OF BRITISH COLUMBIA DOES NOT PROVIDE COVERAGE FOR CHIROPRACTIC CARE. HOWEVER, MOST EXTENDED HEALTH PLANS DO PROVIDE COVERAGE FOR CHIROPRACTIC CARE. IF YOU HAVE INSURANCE THAT COVERS CHIROPRACTIC, WE WILL GIVE YOU ALL OF THE INFORMATION YOU NEED TO HELP YOU GET REIMBURSED QUICKLY.

WE HAVE FOUND IT IS EASIER, FOR YOUR RECORD KEEPING, & OURS, IF WE GIVE YOU RECEIPTS AT THE END OF YOUR FIRST VISIT & THEN ONCE A MONTH AFTER THAT. JUST SEND IN YOUR RECEIPTS TO YOUR INSURANCE COMPANY WITH A COPY OF YOUR CLAIM FORM & THEY WILL COMMUNICATE WITH YOU ABOUT YOUR REIMBURSEMENT. REMEMBER, YOUR AGREEMENT WITH YOUR INSURANCE COMPANY IS BETWEEN YOU & THEM.

CANCELLATION POLICY

Please keep your appointment! If you cannot keep your appointment, please respect our office's cancellation policy by providing a minimum of 3 hours notice for all cancellations. A missed appointment is one that might have been used by another patient. Late or missed appointments are your responsibility, & **may** result in a \$25.00 missed appointment fee being charged to you personally.

◆ **ALL FEES ARE TO BE PAID AT THE TIME OF SERVICE** ◆
◆ **WE ACCEPT CASH, CHEQUE, DEBIT AND CREDIT CARDS** ◆

I am ultimately responsible for all of my charges at this office, regardless of insurance coverage.

I have read, understand, and agree to this financial policy.

SIGNATURE

DATE

PITT MEADOWS WELLNESS CENTRE



...experience life!

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

** This is NOT a waiver **

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) *While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques;*
- b) *There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote;*
- c) *There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.*

HEALTH: A state of optimal physical, mental and social well-being; not merely the absence of disease.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method is by specific adjustments of the spine and other joints.

SUBLUXATION: A misalignment or restriction of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This results in a lessening of the body's innate ability to express its maximum health potential. Subluxations may also occur in other joints in the body.

OUR MAIN OBJECTIVE, and the goal of chiropractic, is to eliminate interference to the expression of the body's innate intelligence and its healing potential. Our method uses specific adjustments to correct subluxations.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor, Dr. Jason Casey and/or Dr. Liz McCrindle, the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

PRINT NAME

SIGNATURE OF PATIENT
(OR PARENT OR GUARDIAN)

DATE

WITNESS TO SIGNATURE ABOVE