Community Chiropractic Center

☐ Dr. Todd Small
☐ Dr. Sarah Dale

116- 11811 Tecumseh Rd. E
Tecumseh, ON N8N 4M7
P: 519-735-7555 F: 519-735-7917
Email: info@communitychiropractic.ca

Confidential
Patient Health History

Date: _____ Patient No.: _____

Name: _____ ☐ Male ☐ Female

Address: _____

City: _____ Postal Code: _____

Phone: _____ Health Card #: _____

Date of Birth: __ __ __ __ - __ __ - __ __ (Year Month Day) Age: _____ Family Doctor: _____

Email Address: _____ Referred By: _____

Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____

Spouse's Name: _____

Names & Ages of Children: _____

Have you received previous chiropractic care? ☐ Yes ☐ No If Yes:

From whom: _____ When: _____

Consent for Physical Examination

I, _____, hereby consent for my initiating chiropractor to perform a physical examination of the region and associated regions of my chief and secondary complaints.

Signature: _____ Date: _____

Consent to Receive Emails/Text Messages

I, _____, hereby give consent to Community Chiropractic Center to send me text reminders, text messages, and emails.

Signature: _____ Date: _____

Symptoms and Ill Health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

Present reason for consulting our office:

- ☐ Correction and prevention of existing problem.
- ☐ Maximizing personal and/or family health potential.

If you have a specific chief complaint, describe briefly. If not, please go to the next page.

_____

_____

How and when did this problem start?

_____

Is there a previous history?

_____

Does the pain radiate or travel anywhere else? _____

Is the problem… ☐ Constant ☐ Intermittent ☐ Worse with movement

Is the problem worse… ☐ In the A.M. ☐ In the P.M. ☐ No change

Is the condition interfering with… ☐ Sleep ☐ Work ☐ Routine ☐ Other: _____

Is the condition getting progressively worse? ☐ Yes ☐ No

Pain is… ☐ Sharp ☐ Throbbing ☐ Dull ☐ Aching ☐ Shooting ☐ Nagging

What aggravates your condition/pain? _____

What relieves your condition/pain? _____

If your condition was treated in the past, please describe treatment and results.

_____

_____

_____

Have you had x-rays taken of this area? ☐ Yes ☐ No

Secondary Complaints?

_____

_____

_____

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Have you ever or do you presently suffer from any of the following symptoms?
Please list present treatment and include any medications being taken.

☐Headaches	☐Ears Ring	☐Stiff/Painful Neck	☐Nervousness
_____	_____	_____	_____
☐Depression	☐Tension	☐Fatigue	☐Sleep Problems
_____	_____	_____	_____
☐Chest Pains	☐Heart/Lung Trouble	☐Digestive Disorders	☐Menstrual Problems
_____	_____	_____	_____
☐Numbness or Pins & Needles in Arms	☐Numbness or Pins & Needles in Legs	☐Cold Feet/Hands	☐Arthritis – Where?
_____	_____	_____	_____

Is there any other medication or treatment you are receiving? (Include Birth Control pills)

_____
_____

List any surgeries and include when?

_____
_____

What, if any, side effects have you experienced from your medications or surgery?

_____

Do you suffer from or is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other
Self	☐	☐	☐	☐	☐	
Mothers Side	☐	☐	☐	☐	☐	
Fathers Side	☐	☐	☐	☐	☐	

About Your Care

Chiropractic treatment provides three types of care. The first is Initial **Intensive Care**, which corrects the most recent layer of spinal and neurological damage. This care usually reduces or eliminates the symptoms. Next is **Reconstructive Care**, which corrects the years of damage that occurred when there were a few symptoms. And finally, chiropractic offers a genuine approach to **Wellness Care**. All these care options will be explained with your report of findings, then you will be able to begin a course that fits your health goals.

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Events and Habits

NEONATAL TO ADULT: Many problems have roots in early spinal and/or neurological damage.

	Yes	No	Comments
1. PREGNANCY: Did your mother…			
Experience any falls/injuries during pregnancy?	☐	☐	_____
Experience distress during delivery?	☐	☐	_____
Experience any prolonged illness?	☐	☐	_____
2. GROWING YEARS			
Were you taught how to care for your spine?	☐	☐	_____
Any notable falls?	☐	☐	_____
Any significant childhood injuries or illnesses?	☐	☐	_____
Any childhood surgeries?	☐	☐	_____
Any prolonged medications?	☐	☐	_____
Mental or physical abuse?	☐	☐	_____
3. ADULTHOOD			
Ever in a motor vehicle accident?	☐	☐	_____
If yes, when?	☐	☐	_____
Any trauma or symptoms?	☐	☐	_____
Any notable falls or injuries as an adult?	☐	☐	_____
Any bone fractures / surgery?	☐	☐	_____
Hobby or sports injuries?	☐	☐	_____
Smoke?	☐	☐	_____
Drink alcohol?	☐	☐	_____
☐ Daily ☐ Weekends ☐ Sporadically			
Exercise Regularly?	☐	☐	_____
☐ Daily ☐ Weekends ☐ Sporadically			
Proper posture?	☐	☐	_____
Eat as healthy as you think you should?	☐	☐	_____
Are you or have you ever been overweight?	☐	☐	_____
Occupational stress?	☐	☐	_____
Repetitive lifting/bending?	☐	☐	_____
Continuous sitting/standing?	☐	☐	_____
Extensive computer work?	☐	☐	_____
Physical stress?	☐	☐	_____
Mental stress?	☐	☐	_____
Other traumas or problems?	☐	☐	_____
Sleep posture ☐ Side ☐ Back ☐ Stomach			_____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
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 adjustment, manipulation 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 treatment 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 also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **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 a burn may occur in association with the 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 can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not know their disc condition is worsening because they only experience back or neck problems occasionally.

  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 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 –** Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or because of an injury. A blood clot may form in a damaged artery. All of 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 travelling up to the brain.

  Chiropractic treatment has also been 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 paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise 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.

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.

_____
Name (Please Print)

_____ Date: _____
Signature of Patient (or legal guardian)

_____ Date: _____
Signature of Chiropractor

Dr. Todd Small
Dr. Sarah Dale

Provider:
Community Chiropractic Center
Dr. Todd Small & Dr. Sarah Dale
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Tecumseh, ON
N8N 4M7
519-735-7555

Please read carefully and sign:

I am aware that it is my responsibility to cover all fees for services and/or products rendered by Community Chiropractic Center (CCC) and will do so upon request.

Signature: _____ Date: _____

Benefit Assignment Form for Direct Billing

Patient Name: _____
File: _____
Phone #: _____
Insurance Co.: _____ Insurance Co. _____
Plan/Policy #: _____ Certificate #: _____

I hereby assign benefits payable for eligible claims to CCC who is responsible for submitting my claims electronically to the group benefits plan. I authorize the insurer/plan administrator, I understand that I remain responsible to payment to CCC for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this assignment, that any benefit payment made in accordance with this assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by CCC and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefits to CCC.

Name (Please Print): _____

Signature: _____ Date: _____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

INFORMED CONSENT FOR ACUPUNCTURE

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.
Acupuncture involves the insertion of small, sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues.
- Are pregnant or actively trying to be.
- Have been fitted for a pacemaker or other electrical implants.
- Have a bleeding disorder or take anticoagulants.
- Have damaged heart valves or have a high risk of infection.
- Suffer from metal allergies.
- Are immune compromised.
- Have had prosthetic implants.

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after every treatment.

Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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.**

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.

_____	_____	_____
Name (Please Print)	Signature of Patient (or legal guardian)	Date
_____		_____
Signature of Chiropractor		Date

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COVID-19 RISK INFORMED CONSENT

In order for you to be seen today by the doctors, you need to meet the following criteria

1. You have NOT experienced any symptoms of COVID-19 in the last 14 days.

   Symptoms can include:
   - Fever
   - New Cough
   - Difficulty Breathing
   - Sore Throat
   - Runny Nose

   Initials: _____

2. You have NOT been in contact with anyone in your household or at your place of work with these symptoms, or a person who has had a positive diagnosis of COVID-19.

   Initials: _____

3. You have NOT travelled outside of Canada in the last 14 days.

   Initials: _____

Please sign below acknowledging that you understand and that you agree to receiving treatment.

Name of Patient: _____

Patient Signature: _____

Date: _____