

Welcome to Our Office

Outline of Procedures for New Chiropractic Practice Members

Step 1

All New patient members are requested to complete a confidential “practice member health record”

Step 2

Your first consultation with the doctor to discuss your health problems and gain insight into the cause of your condition, and help to determine if chiropractic care is appropriate for your condition. Since you are the most important participant in your recovery, it is critical that you not hesitate to ask any questions should they arise.

Step 3

An in depth, advanced assessment of your nervous, muscular and skeletal systems will be conducted using the following tests: Computerized nerve and muscle analysis, spinal function, range of motion, postural assessment, muscle testing, orthopedic, neurological and chiropractic testing. As well, if indicated, x-rays will be ordered to visualize the location and extent of spinal change and damage.

Step 4

Except in extreme cases, patients are not treated on their first visit. This is the time to allow me to get to know how your body works, followed by a careful review of the information obtained from the consultation, examination, and any necessary tests. Based on these findings and your goals, I will design an individualized protocol of care for you.

Step 5

You will return for your **Report of Findings** when I 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.

Step 6

Chiropractic care will begin after your report of findings and continue as scheduled until your condition has been fully corrected, or until maximum possible improvement has been obtained.

Step 7

You will be advised of a convenient time you can return for a **Health and Wellness Workshop** during which time you will learn what you can do to help yourself get the most out of your care in the shortest amount of time and at the lowest cost. The cost for this class is included in your examination fees, and it will last about 45 minutes.

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

Thank you!

PERSONAL HISTORY

Date: _____

Name: _____ Address: _____
 City: _____ Province: _____ Postal Code: _____
 Home Phone: (____) _____ Date of Birth: _____ Age: _____ Sex: M F
 Work Phone: (____) _____ Occupation: _____
 Cell Phone: (____) _____ E-mail: _____
 Married Single Widowed Divorced Separated Number of Children & ages _____
 Emergency Contact: _____ Phone Number: _____ Relationship: _____
 Whom may we thank for referring you to our office? _____
 Family Physician: _____ Previous Chiropractor _____

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here for Chiropractic Wellness Services, and skip to the Family Health Profile.

CURRENT HEALTH CONDITION

Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

Current Complaint(s): _____

If you are experiencing pain, is it...

Sharp Dull Constant Comes and goes Travels Pins & Needles/numb

Since the problem started, is it... About the Same Getting better Getting worse

What makes it worse? _____

How long have you been living with this problem? _____ Has it happened before? _____

How does this problem interfere with:

Your ability to work? _____

Your ability to enjoy your family or social time? _____

Your ability to enjoy your hobbies or sports? _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Do you suffer from any other condition than the one you are now consulting us for? _____

Other Doctors seen for this problem? Yes No Who? _____

Type of Treatment: _____ Results: _____

Please list any prescription or over the counter medications you are taking: _____

FAMILY HEALTH PROFILE

Please indicate any health issues or concerns that are present in your family:

Spouse: _____

Parents: _____

Siblings: _____

Children: _____

Does any member of your family suffer from the same condition? Yes No Whom? _____

Have your children ever had a spinal check-up? No Yes If yes, where and when? _____

Your Health Profile

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, and may not even be felt until they become serious.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE	COMMENTS:
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play any youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug use? (Legal and/or illegal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen /jumped from a height Over three feet? (i.e. crib, bunk-bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas? (physical Or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular Chiropractic Care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

ADULT - (18 YEARS TO PRESENT)

Do / did you smoke? (Or second hand smoke)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do /did you use any recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
What is your daily Caffeine Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do /did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your stress level:

(1 = none / 10=Extreme)

Occupational _____

Personal _____

What is the biggest stress in your life? _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

What Vitamins or supplements do you take on a regular basis, and what is their monthly cost?

Symptom Review

Below is a list of symptoms and diseases, which may seem unrelated to the purpose of your appointment, but which can give insight into the cause of your condition and also affect your overall course of care. Please check (✓) all symptoms you have had in the last year or which have been significant in your life.

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of smell/taste | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Stiff Neck / Neck Pain | <input type="checkbox"/> Buzzing/Ringing in ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Get Sick Often | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Difficulty Conceiving |
| <input type="checkbox"/> Weakness in hands/arms | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Problem Urinating |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Menstrual Pain/irregularity | <input type="checkbox"/> Loss of bowel/bladder control |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Ankle or foot problems |

Office Policies & Fees

For the office to run most efficiently and for us to serve you best, we ask that:

- 1) You be punctual for your appointments and understand that your appointment is set aside and personalized for you. As such, we require 24 hours in the event of a cancellation. A missed visit without proper notice will result in a \$45 charge to your account.
- 2) You understand that each treatment builds upon the last. As such, we ask that you commit to making up any missed appointments within a seven-day period to ensure that your plan of care is not interrupted.
- 3) You settle your account upon each visit

Fee Schedule

New Patient Consultation & Examination	\$125
Regular office visit	\$45
Comparative Re-examination	\$45
Extended office visit (Acupuncture or extended soft tissue)	\$75
Acupuncture alone	\$40
Custom Orthotic supports	\$450 - \$500
Nutritional supplementation	Varies by product

- Please check (✓) here if you would like to be part of the Movestrong mailing list to receive our Health & Wellness newsletter, and be notified of Movestrong events & workshops. This information is not shared with any third party.

I _____ have read the above information and agree to the above office policies. The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Date: _____

Signature: _____