CityView Chiropractic
Sports Injury & Therapeutic Exercise

PATIENT INTAKE FORM

THE INFORMATION YOU PROVIDE IS FOR THE CONFIDENTAL USE OF THIS OFFICE AND WILL ONLY BE RELASED WITH YOUR WRITTEN CONSENT, OR IF YOUR TREATMENT IS COVERED UNDER THE WORKERS' COMPENSATION ACT.

DATE:

FIRST NAME: LAST NAME:

ADDRESS:

STREET *APT#*

CITY *PROVINCE* *POSTAL CODE*

TELEPHONE HOME:

CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH:

HOW DID YOU HEAR OF CITYVIEW CHIROPRACTIC?

PATIENT REFERRAL ☐ YES ☐ NO IF YES, PATIENT NAME

INTERNET: ☐ YES ☐ NO

OTHER:

DO YOU HAVE EXTENDED HEALTH COVERAGE? ☐ YES ☐ NO

HAVE YOU SEEN A CHIROPRACTOR BEFORE? ☐ YES ☐ NO

PATIENT PAST HISTORY FORM

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD RECENTLY

☐	**FEVER**	☐	**HIGH BLOOD PRESSURE**	☐	**GROIN PAIN**
☐	**NIGHT SWEATS**	☐	**LOW BLOOD PRESSURE**	☐	**HERNIA**
☐	**LOSS OF WEIGHT**	☐	**CHEST PAIN**	☐	**HYPO/HYPER THYROID**
☐	**HEADACHES**	☐	**SWELLING OF ANKLES**	☐	**GALL BLADDER TROUBLE**
☐	**DIZZINESS**	☐	**CHRONIC COUGH**		
☐	**LOSS OF CONCIOUSNESS**	☐	**DIFFICULTY BREATHING**		
☐	**NECK PAIN**	☐	**EMPHYSEMA**		
☐	**NECK STIFFNESS**			☐	**STROKE**
☐	**EYE PAIN**			☐	**HEART ATTACK**
☐	**LOSS OF VISION**			☐	**ATHEROSCLEROSIS**
		☐	**LOW BACK PAIN**	☐	**DIABETES**
		☐	**PROSTATE ENLARGEMENT**	☐	**OSTEOPOROSIS**
☐	**ASTHMA**	☐	**BLADDER INFECTION**	☐	**GOUT**
☐	**HAY FEVER**	☐	**KIDNEY INFECTION**	☐	**CANCER**
☐	**SINUS INFECTION**			☐	**DEPRESSION**
☐	**HIVES OR ALLERGIES**				
☐	**RHEUMATOID ARTHRITIS**				
☐	**DEGENERATIVE ARTHRITIS**				

LIFESTYLE HABITS

DO YOU SMOKE? ☐ YES ☐ NO

DO YOU EXERCISE? ☐ YES ☐ NO TIMES PER WEEK

DO YOU SLEEP WELL? ☐ YES ☐ NO HOURS EACH NIGHT

PREVIOUS FALLS OR ACCIDENTS?

PAST SURGERIES?

DO YOU TAKE VITAMIN OR SUPLEMENTS? ☐ YES ☐ NO

MEDICATIONS?

FAMILY HEALTH PROBLEMS?

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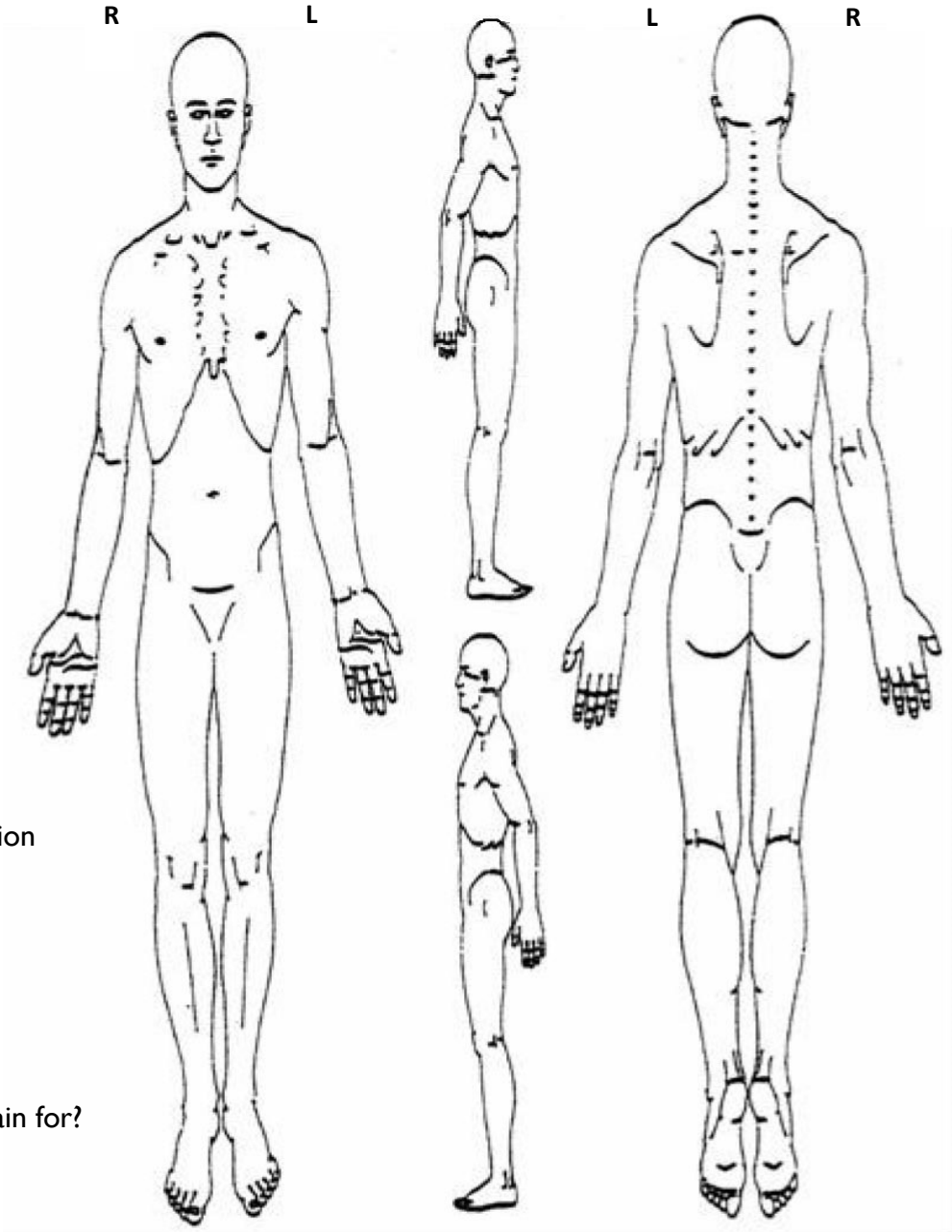
PATIENT NAME: **DATE:**

In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

SYMBOLS:

Numbness:	**====** **====**
Burning:	**xxxx** **xxxx**
Dull & Aching:	**++++** **++++**
Pins & Needles	**.....** **.....**
Stabbing & Sharp	***wwww*** ***wwww***
Stiff & Tight	**2 2 2 2** **2 2 2 2**



FRONT **BACK**

Please provide a brief description of how this injury occurred:

- ☐ Is the pain constant?
- ☐ Intermittent?
- ☐ Activity based?

How long have you had this pain for?

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PRIVACY POLICY

*Privacy of personal information is an important principal to **City View Chiropractic Clinic**. We are commitment to collecting, using and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle personal information. This document describes out privacy policies.*

WHAT IS PERSONAL INFORMATION?

Personal information is information about an identifiable individual. Personal information includes information that relates to their personal characteristics (e.g. gender, age, income, home address, phone number, ethnic background, and family status), their health (e.g. health history, health conditions, health services received by them) or their activities and views (e.g. religion, politics, opinions expressed by an individual, an opinion or evaluation of an individual). Personal information is to be contrasted with business information (e.g. an individual's business address and telephone number), which is not protected by the privacy legislation.

WHO WE ARE

Our organization, **City View Chiropractic Sports Injury and Therapeutic Exercise**, includes at the time of writing, one Doctor of Chiropractic, two associate Doctor of Chiropractic, two independently contracted registered massage therapists, and six support staff. We use several consultants and agencies that may, in the course of their duties, have limited access to personal information we hold. These include computer consultants, office security and maintenance, bookkeepers and accountants, temporary workers to cover holidays, credit card companies, website managers, cleaners, and lawyers. We restrict their access to any personal information we hold as much as it is reasonably possible. We also have their assurance that they follow appropriate privacy principals.

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CONSENT FOR THE COST OF OUR SERVICES

Initial Chiropractic Visit + X-ray Requisition	$120.00
Initial Chiropractic Visit	$100.00
Reevaluation (after 6 months or new injury)	$80.00
Shockwave	$100.00
Follow up Treatment (adjustment, MFR, modality)	$60.00
Adjustment only	$50.00
Exercise Treatment	$25.00-$68.00

Massage Therapy

90 minutes	$165.00 + HST
60 minutes	$100.00 + HST
45 minutes	$80.00 + HST
30 minutes	$60.00 + HST

Other Information:

Company Extended Health Care Plans may or may not cover Chiropractic care and massage therapy. It is the responsibility of the patient to check their individual plans for the specifics of your individual coverage. If your injury is work-related, (WSIB) please inform your doctor and your workplace within 48 hours of the injury. If your injury is the result of a Motor Vehicle Accident (MVA) please advise the clinic and call your insurance agency for the particulars of your benefit package. If your extended health provider, WSIB, or any other third-party coverage does not honor any claims, our fee becomes the sole responsibility of the patient.

We accept VISA, Master Card, American Express, Interact or EXACT Cash.

SIGNATURE *DATE*

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Chiropractic and Massage goods and services, City View Chiropractic Clinic will collect some personal information about me (e.g. home address and telephone number).

SIGNATURE *DATE*

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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 adjustments, 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 on the body caused by nerve, 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.

● 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 have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. 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 conditions.

The consequences of disc injury or aggravating a pre-existing disc 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.

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● Stroke – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakend and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or 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 an traveling 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 the 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 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

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

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