Name:		Date:
Address:		
City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:
Email:	Marital Status:	
Name Of Family Physician (MD):		
Age:	Occupation:	Employer:
Extended Health Care Company:		Policy #:
Who May We Thank For Referring You?		
Are you here as a result of a motor vehicle accident? Y ☐ N ☐		Claim #:
Are you here as a result of a work related accident? Y ☐ N ☐		Claim #:

History of Present Condition

Describe your major complaint(s):	
How did this happen?	When did this happen?
Has this ever happened before? ☐Yes ☐No	How would you rate your pain severity? /10
How would you describe the symptoms: ☐sharp ☐shooting ☐stabbing ☐weakness ☐dull ☐stiffness other: ☐numb ☐tingling ☐spasm ☐burning ☐achy ☐throbbing	
What makes your symptoms better:	What makes your symptoms worse:
Does the pain radiate/ travel anywhere? ☐Yes ☐No Where?	How often do you experience these sypmptoms? ☐Intermittently ☐Frequently ☐Constantly
Have you received any form of treatment for your condition? ☐ Yes ☐ No If Yes, what form?	Have you obtained X-Rays, MRI, EMG, CT scans or Lab work? ☐ Yes ☐ No If Yes Which?

Past Health History

		Yes	No	If Yes Please Explain……
Have You….	Been hospitalized in the last 5 years?	☐	☐	
	Had any surgeries	☐	☐	
	Suffered any major physical trauma?	☐	☐	
	Suffered any broken bones ?	☐	☐	

For each of the conditions listed below, place a check if you are, or have in the past, experienced any of the following:

☐	Headaches	☐	Heart Attack	☐	Excessive Thirst
☐	Neck Pain	☐	Chest Pains	☐	Frequent Urination
☐	Upper Back Pain	☐	Stroke	☐	Chronic Sinusitis
☐	Mid Back Pain	☐	Angina	☐	Smoking/ Tobacco Products
☐	Lower Back Pain	☐	Kidney Stones	☐	Drug / Alcohol Dependence
☐	Sciatica	☐	Kidney Disorders	☐	Allergies
☐	Shoulder Pain	☐	Bladder Infection	☐	Depression
☐	Elbow or Upper Arm Pain	☐	Painful Urination	☐	Systemic Lupus
☐	Wrist Pain	☐	Loss of Bowel or Bladder Control	☐	Epilepsey
☐	Hand Pain	☐	Prostate Problems	☐	Dermatitis/Eczema/Rash
☐	Ankle/Foot Pain	☐	Abnormal Weight Loss or Gain	☐	HIV / AIDS
☐	Jaw Pain	☐	Diminished Appetite		**Women Only**
☐	Joint Swelling or Stiffness	☐	Abdominal Pain	☐	Birth Control Pills
☐	Arthritis	☐	Ulcer	☐	Pregnancy
☐	Rheumatoid Arthritis	☐	Hepatitis	☐	Hormonal Replacement
☐	General Fatigue	☐	Liver or Gall Bladder Disorder		**Other Health Issues**
☐	Fibromyalgia	☐	Cancer Type:	☐	
☐	Visual Disturbances	☐	Tumor	☐	
☐	Dizziness	☐	Osteoporosis	☐	
☐	High Blood Pressure	☐	Asthma	☐	
☐	Heart Arrythmias	☐	Diabetes	☐	
☐	Pace Maker	☐	Aneurysm	☐	

Family History: If any blood relative has any of the following conditions, please check and indicate which relative

☐ Anemia	☐ Diabetes	☐ High Blood Pressure
☐ Atherosclerosis	☐ Disc Disorder	☐ High Cholesterol
☐ Arthritis	☐ Emphysema	☐ Multiple Sclerosis
☐ Asthma	☐ Epilepsy	☐ Osteoporosis
☐ Back Ache	☐ Glaucoma	☐ Pinched Nerve
☐ Bleed Easy	☐ Headaches	☐ Stroke
☐ Cancer	☐ Heart Trouble	☐ Thyroid Disease

Medications: Please list any medication you are currently taking and why

Type	Purpose

Please Indicate any other information that may be relevant to your condition:

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 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 condition.

  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.
- **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 Chiropractic treatment has also been associated with stroke. However, that association occurs

very infrequently, and 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 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.

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: _____20_____
Signature of patient (or legal guardian)

_____
Signature of Chiropractor

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent for Acupuncture Care FORM - AC

Please Read Carefully

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including moxibustion, cupping, and/or electroacupuncture by the above-named doctor or another duly authorized doctor in the clinic.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

READ BEFORE SIGNING

_____	_____	_____
Date Signed	**Print Patient's Name**	**Signature of Patient (or parent/guardian)**

Tom McChesney
Chiropractic and Sports Rehab

Fee Schedule

Initial Visit: $80

Subsequent visit: $50

Chiropractic Adjustment + Acupuncture: $50

Chiropractic Adjustment: $50

Medical Acupuncture: $45

Active Release Technique: $40

30 minute Rehabilitation Session: $60

Please provide 24hrs notice of any cancellation or re-scheduling of appointments. A "No-Show" fee of 40$ will be administered for all missed appointments.

WSIB CLAIM STATUS ONLY: I acknowledge that it is my responsibility to insure that my claim has been accepted by WSIB I agree to pay all assessment and treatment fees if my claim or treatment is not approved.

Please sign below that you are aware of the fee schedule and agree to make payment following every visit.

Name: _____

Signature: _____ Date: _____