Chiro Clinic
PHYSIO & MASSAGE

CHIROPRACTIC

Confidential Patient Information

Title: ___ Name: _____ Date of Birth: _____ Age: ___ Gender: M / F

Address: _____City: _____Postal Code: _____

Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____

E-mail: _____ Occupation: _____

Medicare #:_____ Do you have Insurance? Yes / No _____

Who recommended you to this clinic? _____

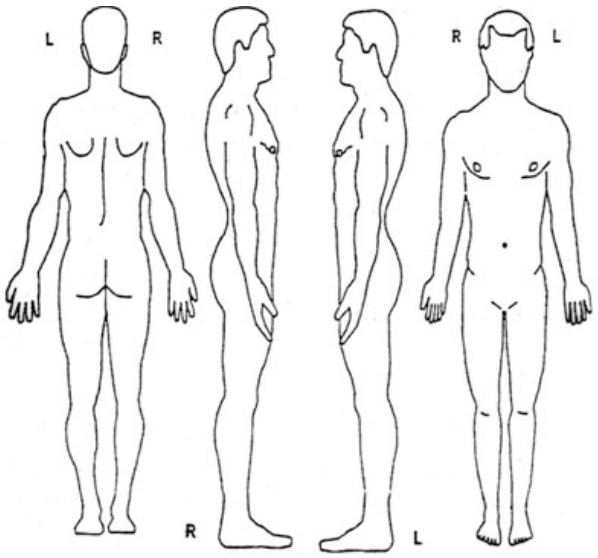
Family Doctor: _____ Clinic: _____

Emergency Contact: _____ Relationship: _____ Ph #: _____

PRIMARY REASON FOR ASSESSMENT: _____

How severe is your pain?

No pain — Worst pain imaginable



How would you describe the problem? _____

What caused your present condition? _____

How long have you had this condition? _____ Where does the pain radiate? □ Arm □ Leg □ Nil

When is the condition worse? □ Morning □ Evening □ During the night Is it waking you at night? □ Yes □ No

Does anything aggravate the condition? □ Lying □ Standing □ Sitting □ Movement □ Other _____

Does anything relieve the condition? □ Yes □ No If yes, please explain _____

The condition is: □ Getting Better □ Getting Worse □ Staying the Same

Have you had Treatment for this condition? □ Yes □ No By Whom: _____ Result: _____

Have you ever consulted a Chiropractor? □ Yes □ No By Whom: _____ Result: _____

What percentage of the day do you experience these symptoms? 100% 75% 50% 25% 10%

What is your goal? □ Pain Relief □ Increased Movement □ Preventative Care □ Rehabilitation □ Other_____

Have you recently experienced any of the following? (*Please write "Y" for Yes or "N" for No & Circle those that apply*)

Fever/Nausea/Vomiting __	Night Pain/Sweats __	Unexplained Weight Loss __
Bowel/Bladder Habit Change __	Difficulty to Speak/Swallow __	Dizziness/Vertigo __
Visual/Hearing Problems __	Fainting/Light-Headedness__	Numbness in Groin Region __

Do you smoke tobacco? Yes / No If yes, how many per day? _____
Do you drink alcohol? Yes / No If yes, how many per day? _____
Do you use recreational drugs? Yes / No If yes, which? _____ How often? _____

Do you have a Pacemaker? Yes / No
Do you take any Medications? Yes / No If yes, which? _____
Do you take any Supplements? Yes / No If yes, which? _____

In your lifetime, have you ever experienced any of the following: (*Please be specific*)

□ Broken Bones: _____

□ Dislocations: _____

□ Infections: _____

□ Hospitalizations: _____

□ Surgeries: _____

□ Cancer/Diabetes/Stroke: _____

□ Other: _____

If you are Female, is there any chance you could be Pregnant? Yes / No / Maybe

Do you engage in regular physical activity? Yes / No If yes, which? _____

How many times per week do you engage in physical activity? _____ Is it high intensity? Yes / No / Rarely

What is the average duration of physical activity? □ <10min □ 10-20min □ 20-30 min □ 30-60 min □ >60 min

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

1. a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
2. b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does **not** establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely rare;
3. c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
4. d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent. I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Date: _____ Name (Please Print): _____ Signature: _____

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Your Privacy: Our Policy

The provision of quality health care requires a doctor-patient relationship of trust and confidentiality. Consistent with our commitment to quality care, Chiro Clinic Moncton has developed a policy to protect patient privacy in compliance with current legislation.

Collection

We will collect information that is necessary to properly treat you. Such necessary information may include;

- Full medical history, family medical history, contact details etc.
- Medicare/private health insurance details and billing/account details

The information will normally be collected directly from you. There may be an occasion when we will need to obtain information from other sources;

- Medical practitioners (I.e. family doctors, chiropractors, and specialists etc)
- Other providers such as physiotherapists, occupational therapists, psychologists, pharmacists, massage therapists, dentists, hospital and day surgery units.
- Rehab practitioners (exercise physiologists, personal trainers, kinesiologists)
- New Brunswick Electronic Health Records containing your Personal Health Information

Use & Disclosure

With your consent, the practice staff will potentially use and disclose your information for:

- Account keeping and billing purposes for the management of our practice.
- Referral to another medical practitioner or health care provider.
- Referral for further tests (I.e. X-rays, MRI, Ultrasound etc)
- Referral to a hospital for treatment options.
- Clinic updates and newsletters via email.
- Quality assurance, practice accreditation and complaint handling.
- To prevent or lessen a serious threat to an individual's life, health or safety.
- Where legally required to do so, such as producing record to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
- Contacting your next of kin or emergency contact to disclose sensitive information regarding your case in the event of an emergency, as deemed appropriate by the practitioners at this practice.
- Electronic practice management and health record keeping, where information shall be stored on servers located within Canada or abroad.

Consent

I provide my consent for the staff and practitioners at Chiro Clinic Moncton to collect, use and disclose my personal information as outlined above. I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Date: _____ Name (Please Print): _____ Signature: _____