Chiropractic Intake

Name ____ Sex: M F Date ____________________

Care Card # ____________________________ Date of Birth (mm/dd/yyyy) ______________ Age ____________

Address ______________________________ City ______________ Province ________ Postal Code ____________

Home Phone ________________ Work Phone ____________________ Cell Phone ____________________

Would you like appointment reminders? → □ Email ______________________________________ □ Text □ No reminders

Medical Doctor ________________ Who referred you to this clinic? Google/Drove By/Friend/Fix Healthcare Sign/ Other ____________________

Is this an ICBC claim? Would you like us to do direct billing for you (ICBC/Lawyer?) Y / N Claim #: ____________________

Injury Date: __________ Adjustor's name: __________ Adjustor's direct phone #: ____________ Lawyer (if applicable): ______________

Who did you see for the first treatment after your injury? (name / occupation): ________________________________

Please note that we do not accept WCB claims. Please notify reception immediately if you have come in for treatment for a workplace injury.

Please circle your insurance company below if you would like us to direct bill them.

Plan # ____________ Id # ____________ Primary's full name (if not you) ______________________________

Primary's birthdate (mm/dd/yyyy) ______________ Primary's Plan # ______________ Primary's Id # ________________

What is the reason for your visit? ____

Please draw the location of your complaint on the picture.

What treatment have you tried for this, including medications?

____

When did this condition start? ____________________________

Has it occurred before? YES / NO

How did it happen? ____________________________

Is it related to job or auto accident? JOB AUTO No

What makes it feel worse? ____________________________

What makes it feel better? ____________________________

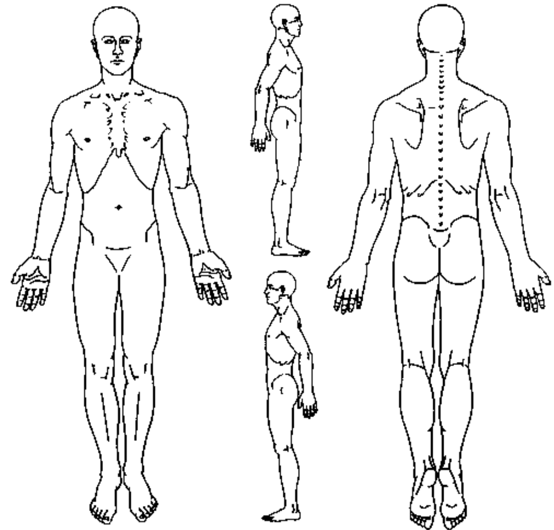
Since it started, is it getting better or worse? Better / Worse

What is the severity 0 to 10 (0= No Pain and 10 = Worst)? ________

Does the pain shoot or travel? YES / NO Where? ______________

How often does the pain occur? ________________________

How long does the pain last? ____________________________



YOUR CURRENT HEALTH AND INJURIES

Any Motor Vehicle Accidents? YES / NO What? Dates? ________________________________

Any Work Injuries? YES / NO What? Dates? ________________________________

Any Sports Injuries? YES / NO What? Dates? ________________________________

Have you ever injured your head or lost consciousness? YES / NO

Is the reason for this visit also worsening your sleep? YES / NO

PLEASE TURN OVER AND COMPLETE THE 2nd PAGE

Have you seen a chiropractor before? YES / NO Whom? ______________ When?_______________ Why?____________________

Have you had X-rays taken for your area of complaint? YES / No When? ____________________Where?_________________________

Past Hospitalizations or major illness: ____

Surgeries and operations:____

Are you on any medications/vitamins/over the counter drugs/birth control? ____

Any allergies? ____

DO YOU HAVE A FAMILY HISTORY OF? (Please Circle)

Back/Neck Pain Cancer Diabetes Heart Problems High Blood Pressure Stroke

DO YOU? (Circle and fill in)

Smoke or chew tobacco: Yes, I currently smoke ____ pack(s) / day, and have for _______ years.
No, but I used to. Quit how long ago? ________ How much did you smoke then? _________
Never.

Have interrupted sleep: It has been interrupted_________________ times/night for ______________ months/years.

YOUR HEALTH HISTORY:

Have you experienced any of the following? (Please check all that apply)

- ❑ Fever / chills
- ❑ Recent weight loss or gain
- ❑ Anemia
- ❑ Fatigue
- ❑ Bleeding abnormalities
- ❑ Night Sweats
- ❑ Limitation of movement, where _________________________
- ❑ Headaches, type _________________________
- ❑ Heart disease, heart attack
- ❑ High or low blood pressure
- ❑ High or low cholesterol
- ❑ Changes in vision, hearing, smell, or taste
- ❑ Persistent cough
- ❑ Difficulty breathing
- ❑ Frequent infections
- ❑ Chest pain
- ❑ Stroke
- ❑ Cancer
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Dizziness
- ❑ Seizures, fainting, epilepsy
- ❑ Insomnia
- ❑ Depression
- ❑ Anxiety
- ❑ Phlebitis
- ❑ Varicose veins
- ❑ Diabetes
- ❑ Pregnancy (past/currently)
- ❑ Menstrual problems
- ❑ Constipation
- ❑ Gastrointestinal problems
- ❑ Blood in urine or stool
- ❑ Kidney or bladder problems
- ❑ Psoriasis
- ❑ Contagious skin condition
- ❑ Allergies, type _____________________
- ❑ HIV/AIDS/Hepatitis
- ❑ Swollen joints
- ❑ Spinal curvature/scoliosis
- ❑ Numbness or weakness

Is there anything else not covered here that the doctor should be aware of? NO / YES (Write Below)

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS TO FIX HEALTHCARE

I authorize the Medical Services Plan to pay Fix Healthcare directly for all reimbursements for benefits payable to me under the Medical and Heath Care Services Regulation for care provided to me by my Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for the difference between the office fee and the amount that is reimbursable by the Medical Services Plan ($23). The amount reimbursed by MSP will be directed to Fix Healthcare and be applied against any outstanding monies I owe for services provided.

This form allows your practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his full fee and what portion will be reimbursed by MSP. By agreements, your practitioner may not charge you the portion reimbursable by MSP.

I understand that any MSP benefits over and above the 10 treatments allotted per year will be my responsibility to pay in full at the Private fee rates.

Care Card Number (PHN): ____

Name (print): ____

Signature: ____

Date: ____

FIX HEALTHCARE

INFORMED 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 & 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 issues. 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 only last a few hours to a few days.

- **Skin irritation or burn**: Skin irritation or 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 may also 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 & 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 & travel up the artery to the brain where it can interrupt blood flow & 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 & travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, & 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 & 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 & 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 anytime 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 my 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.

- In consideration of other patients and my practitioner, I understand that a minimum of 24 hours' notice is required to change or cancel appointments. This time has been reserved for you and unattended appointments prevent practitioners from seeing other patients. Patients will be expected to cover the full treatment fee in the case of missed appointments or late cancellations that cannot be booked by another patient. Please be advised that non-attended appointments cannot be billed to insurance providers. Thank you for your consideration.

- If I am using my extended benefits, I authorize Fix Healthcare to direct bill online on my behalf and receive payment for my treatments directly. I agree that I will be responsible for any fees which are not covered by my insurance, including those which may initially be accepted but later refused by my insurance.

- DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR -

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