Active Chiropractic Family Health Centre

Chiropractic Health History Form
MVA

Office Use Only			
☐ MB		☐ Ref.	
☐ Rel.		☐ FV	
☐ IFS		☐ Wel.	
☐ Update			

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a chiropractic treatment. **If your health status changes in the future, please let us know**. **Please notify the front desk if you have moved or if any of your personal information changes, as this affects your receipt for insurance submissions**. All the information gathered for this treatment is confidential, except as required or allowed by law, or to facilitate assessment or treatment by any Chiropractor at Active Chiropractic Family Health Centre. You will be asked to provide written authorization for release of any information. All payments are due prior to service. If you are covered by insurance, and your insurance does not cover any or part of a service you have received, you are liable for this fee.
Each therapist at Active Chiropractic requires 24 hours notice to cancel or reschedule an appointment as we often have a waitlist for acute patients. Failure to do so will result in the full treatment fee being charged (please see our current fee schedule).
If you are covered by insurance:
Please note that you are liable for this cancellation fee and it will not be reimbursed by your insurance carrier. ..... Initials _____

I have read and I acknowledge any and all costs associated with my appointment. ..... Initials _____
Did you know that you can book your appointments online 24 hrs a day 7 days a week? **Ask us how**!

Name:		**Date:** DD/MM/YYYY
Street Address:		**City:**
Email Address:		**Postal Code:**
Courtesy reminder calls and emails: **Phone Call Reminders Y N** **Email Reminders Y N**		
Home Phone:	**Cell Phone:**	**Work Phone:**
Date of Birth: DD/MM/YYYY **Age:**	**Occupation:**	**Male** **Female**
Emergency Contact:	**ER Number:**	**ER Relationship:**

Who referred you to Active Chiropractic?

Did you know that if you refer someone for Chiropractic Care, and they mention your name on their form, that you will receive a **Free Follow-up Chiropractic Treatment.**

Date of Accident: DD/MM/YYYY
Time of Accident (Am/Pm):

Administrative Information Required Prior to your visit:

Insurance Coverage:

1. Is there other insurance coverage available? (ex. through work, spouse etc.) **YES or NO**
2. If **YES**, Are you the Insurance Policy Holder? **Y/N**
3. If **NO**, Who's Policy is it? _____
   What is the Policy #: _____
   Certificate #: _____
   Name of the Insurance Company:_____
   Phone #: _____
   Fax#:_____
4. Have you used any of your chiropractic benefits for this year? **YES or NO**
5. If **YES**, how much have you used? _____
6. Would you like us to submit to your extended health care on your behalf electronically? **Y/N**
7. If **Y**, please fill in the Electronic Submission Form❑

MVA Insurance:

1. Are you the Car Insurance Policy Holder? **YES or NO**
2. If NO, Who's Policy is it? _____
   What is the Policy #: _____
   Certificate #: _____
   Accident Claim#: _____
   Name of the Insurance Company:_____
   Name of Adjuster:_____
   Phone #: _____ Fax#:_____
3. A) Are you seeing any other practitioner for this MVA? **YES or NO**
   If **YES**, who is your Practitioner?_____
   B) Have you seen any other practitioner in the past for this current MVA prior to here? **YES or NO**
   If **YES**, who was your Practitioner? _____
4. Were you employed at the time of the accident? **Y/N**
5. Did you have any diseases/injury prior to the accident? **YES or NO**, please list_____

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Current Symptoms:

Please describe your current symptoms: _____

_____

_____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	IRRITABILITY	REDUCED TOLERANCE TO HEAT
DIFFICULTY CONCENTRATING	DIFFICULTY WITH MEMORY	REDUCED TOLERANCE TO ALCOHOL
SLEEPLESNESS	FORGETFULLNESS	

Please circle your current level of pain 1 2 3 4 5 6 7 8 9 10
1=no pain, 10=worst pain imaginable.

Immediate Details

Did you go to the hospital? YES or NO
If Yes, what was the name AND city of the hospital? _____
How did you get to the hospital? _____
What parts of your body were X-rayed at the hospital? _____
What did the hospital do for your injuries? _____

What bleeding cuts did you sustain during the accident? _____
What bruises did you sustain during the accident? _____
Did you receive any bruises from the seat belt? YES or NO
If yes, please describe _____
Did you lose consciousness (blackout) upon impact? YES or NO
Did you experience a flask of light or explosion in the head? YES or NO

From the accident, did you become (please circle)

CONFUSED	DISORIENTED	LIGHTHEADED	DIZZY
BLURRED	VISION	NAUSEATED	RINGING/BUZZING IN THE EARS

If you still have any of the symptoms, which ones? _____

Accident Details

Please Describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

Road conditions at the time of the accident? **WET DRY ICY OTHER**: _____
Where were you seated in the vehicle? _____
Where you wearing a seatbelt? **YES or NO**
If Yes, was it a lap seatbelt_____ shoulder-lap seatbelt_____
Did your vehicle's airbag deploy? **YES or NO**
Where you aware of approaching collision prior to impact, or did the impact catch you by surprise?
AWARE_____ SURPRISE_____
Was your head pointing forward at the moment of impact? **YES or NO**
If NO, how was it turned? _____
Does your vehicle have a head rest? **YES or NO**
If YES, how far is it above the seat back? _____ Inches

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Was your car stopped at the time of impact? **YES or NO**
If YES, was the driver's foot also on the brake? **YES or NO**
If NO, then estimate the speed of the vehicle you were in:_____kph
If your vehicle was moving at the time of impact, was it:
Slowing down_____gaining speed _____travelling at a steady rate of speed_____

On what part of the automobile did your following body parts hit?
Head hit_____ Chest hit_____
Right/left shoulder hit_____ Right/left arm hit_____
Right/left hip hit _____ Right/left leg hit_____
Right /left knee hit _____ Other_____

Which of the following car parts broke during the accident? Please Circle
Windshield Front Sheet
Right/left side window Other_____
Steering Wheel Other_____

Approx. Damage to vehicle? Totalled or Smashed

Current Medication(s) and condition it treats:

Primary Care Physician (Name/Address/Phone)

Are you currently receiving treatment from another health care professional? Yes No

If Yes, for what?

Have you ever had surgery? Yes No
If yes, Nature/Date(s):

Have you ever been hospitalized? Yes No
If yes, Nature/Date(s):

Other injuries: Yes No

If yes, Nature/Date(s):

Do you have any internal pins, wires, artificial joints, or special equipment? Yes No
If yes, What?/Where?

Do you smoke? Yes No
If yes, how much: For how long?

Did you smoke in the past? Yes No
If yes, how much: For how long?

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Please indicate conditions you are <u>currently</u> experiencing with ☑ or ○ the conditions you <u>have</u> experienced in the past:

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family history of
- ☐ Respiratory difficulties

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker / similar device
- ☐ Heart disease
- ☐ Family history of cardiovascular difficulties

Infections
- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Infectious Skin / Respiratory

Other conditions
- ☐ Loss of sensation
- ☐ Diabetes (Onset:_____)
- ☐ Allergies/Hypersensitivity (_____)
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis / Family history of
- ☐ Skin conditions _____
- ☐ Osteoporosis / Osteopenia
- ☐ Hemophilia
- ☐ Mental Illness/Nervous Disorder

Head/Neck
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ History of headaches / migraines

Women
- ☐ Pregnant (DUE:_____)
- ☐ Gynecological conditions, What?_____

Soft Tissue / Joint discomfort and its nature:
- ☐ Neck _____
- ☐ Low Back _____
- ☐ Mid Back _____
- ☐ Upper Back _____
- ☐ Shoulders _____
- ☐ Chest _____
- ☐ Arms _____
- ☐ Legs _____
- ☐ Knees _____
- ☐ TMJ _____
- ☐ Other: _____

Overall, how is your general health? (Circle below)

Excellent / Good / Fair / Poor

I have read the above information and have stated all my previous medical conditions. **I take it upon myself to update the Chiropractor regarding any changes in my condition**. I understand that all chiropractic treatments will be discussed and planned with the Chiropractor, and will require my informed consent.

Furthermore, I authorize that the Chiropractors providing care at Active Chiropractic Family Health Centre have full access to my client file.

Patient Signature: _____ Date: _____

I consent to the sharing of my health history information, imagining and reports to the following practitioners of Active Chiropractic Family Health Centre: ____ Chiropractor(s) _____ Registered Massage Therapist(s) _____ Physiotherapist(s) _____Naturopath(s) ____Fitness Trainer(s)

_____ **Signature**

_____ **Date**

Active Chiropractic Health Centre will never sell, trade, rent exchange or otherwise share your personal information with any other person, company, or organization. Privacy is of paramount importance to us. The information you provide us including your name, address, phone numbers, email address, purchases, and credit card information is used to process your service order or registration, to answer your questions, and to send you periodic mailings about our services or upcoming events.

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 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.

Dated this _____ day of _____, 20 _____

_____ _____

Name of **Patient** (Please Print) **Patient** Signature (or Legal Guardian)

Dr. Elizabeth Radley-Walters _____

Chiropractor **Chiropractor's** Signature

Active Chiropractic
Family Health Centre

Under the Canada Anti-Spam Legislation (CASL), effective as of July 1, 2014, we require your consent in order to send you electronic communications; for example, the latest in exercises, nutrition information, class schedules, appointment reminders and any other information that may be of interest to you. To allow us to continue providing information that is relevant to you, please take a moment and check the boxes for the information that you would like to receive.

Active Chiropractic would not want you to miss out on any information that is beneficial to you. ☐

First Name: _____

Last Name: _____

Email address: _____

	Appointment Reminders/Confirmation If you circled 'Yes' on the first page to receive appointment reminder emails please check the box		
	Clinic Newsletter		Massage Therapy
	Chiropractic – News		Kinesiology - News
	BootCamp		Personal Training
	Yoga		Nutrition Counselling
	Running Clinics		Physiotherapy
	Counselling		Concussion Management
	Naturopathic Medicine		
	I do NOT wish to receive ANY emails		

You may withdraw your consent or modify your subscription preferences at any time.

Dated this_____ day of_____, 20_____.

_____ _____

Signature **Name – please print**

_____ _____

Witness - Signature **Name – please print**

Active Chiropractic Family Health Centre

Approved by Council: December 11, 2008
Distributed to members: January 2009

PARTNERSHIP OF CARE

(Patient's Charter of Rights & Responsibilities)

You and your chiropractor have an equal and vital role in the pursuit of your optimum health and well-being.

You have the right to expect your chiropractor to provide…

- ✓ ethical conduct of practice
- ✓ respectful, honest and clear communication in all aspects of care
- ✓ relevant, safe and supportive patient-centred care
- ✓ accurate and comprehensive records
- ✓ an awareness of current health and well-being issues
- ✓ information about what chiropractic offers
- ✓ timely and necessary communication and/or referral to other health professionals
- ✓ timely transfer of records, when appropriate
- ✓ compliance with the College of Chiropractors of Ontario's (CCO) regulations, standards of practice, policies and guidelines (information is posted on CCO's web site at www.cco.on.ca)
- ✓ privacy and confidentiality
- ✓ behaviour and clarity regarding dignified professional boundaries
- ✓ disclosure of real or perceived conflicts of interest
- ✓ a process for declining treatment and withdrawal of consent at any time
- ✓ full disclosure of policies, procedures and fees

Your responsibilities to your chiropractor are to provide…

- ✓ honest, accurate and full disclosure of all pertinent health information
- ✓ constructive feedback (positive/negative) regarding all aspects of care
- ✓ a cooperative commitment to your treatment plan
- ✓ compliance with office policies, procedures and fees
- ✓ courtesy and respect for the office environment, staff and other patients
- ✓ up-to-date contact information\

CCO is the governing body established by the provincial government to regulate chiropractors in Ontario. Every chiropractor practising in Ontario must be a registered member of CCO.

_____ Patient Initials

College of Chiropractors of Ontario
130 Bloor St. West, Suite 902
Toronto, ON M5S 1N5
Web site: www.cco.on.ca

Tel.: 416-922-6355
Fax: 416-925-9610
E-mail: cco.info@cco.on.ca

Electronic Transmission Authorization and Consent Form

This form must be filled out prior to claims submitted electronically by the provider on your behalf. This form must be retained in your patient file for verification purposes for two years following closure of your patient file.

Provider: **Active Chiropractic Family Health Centre**
Address: **1169 Pembroke Street, East**
City/Province: **Pembroke, Ontario**
Postal Code: **K8A 7R4**
Phone Number: **613-732-9215**

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law(s).
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

_____
Date

_____ _____
Print - Name Signature

_____ _____
Witness - Print Witness – Signature