Westney Heights Chiropractic Centre
Dr. David Surette BPHE, BEd, DC / Dr. Karen Martindale-Sliz BSc, DC

PEDIATRIC NEW PATIENT INFORMATAION

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Phone # _____ email Address _____

Mother's Business # _____ Mother's Cell Phone # _____

Father's Business # _____ Father's Cell Phone # _____

Date of Birth (Day/Month/Year) _____Gender: Male / Female

Age _____ Height _____ Weight _____

Extended Health Care Company _____

How did you hear about our office: Family ❑ Friend ❑ Massage Therapist ❑ _____

Internet ❑ Phone book ❑ Sign ❑ Other ❑ _____

PRIOR CHIROPRACTIC CARE

Name _____ Date of last visit _____

Telephone _____ Fax _____

MEDICAL DOCTOR

Name _____ Telephone _____ Fax _____

Address _____

Date of Last Appointment _____ Date of Last Physical _____

MEDICAL TESTS

X-rays MRI CT Scan Ultrasound Other _____

Date of Test _____

Results _____

_____

_____

PREGNANCY AND BIRTHING HISTORY

Duration of gestation _____ weeks

List any significant complications during pregnancy _____

_____

_____

Delivery: Vaginal ❑ C-Section ❑

Duration of labor (hours) _____ Presentation of baby _____

List any complications of delivery _____

_____

_____

List any medication taken during pregnancy _____

_____

List any medication taken during delivery _____

_____

Forceps used for delivery? Yes / No

Place of Birth: Hospital / Home

Apgar Score at birth _____ Apgar Score at 5 minutes _____

Weight at birth _____ Length at birth _____

DEVELOPMENT HISTORY

Was the infant alert and responsive within twelve hours of delivery? Yes / No
If "No" explain _____

At what age did the child?

Respond to sound _____
Hold head up _____
Sit alone _____
Crawl _____
Stand _____

Follow an object with his/her eyes _____
Vocalize _____
Teethe _____
Sleep through the night _____
Walk alone _____

NUTRITIONAL HISTORY

Breastfed _____months. Formula began age _____ for _____ months.

Homogenous milk began age _____ Type of formula used _____

Other milk _____ began age _____ for _____ months.

Began solid food at age _____ months

Were commercially prepared foods used? Yes / No Type _____

Food / juice intolerance? Yes / No Type _____

Does child eat regularly? Breakfast Lunch Dinner Snacks

List any vitamins and minerals the child is taking _____

_____

SOCIAL BEHAVIOUR

Seems normal for age: Yes / No
If "No" explain: _____

CHILDHOOD VACCINATIONS

Chicken Pox	Y / N	Mumps	Y / N	Polio	Y / N
Measles	Y / N	Meningitis	Y / N	Diphtheria	Y / N
Pertussis (Whooping Cough)	Y / N	Flu	Y / N	Tetanus	Y / N
HIB (Haemaphilus Influenza B)	Y / N	Pneumonia	Y / N	Hepatitis B	Y / N

Other: _____

HEALTH HISTORY

Falls and Accidents – describe with dates _____

_____

Surgery and Hospitalizations – describe with dates _____

_____

List any medication or drugs the child is currently taking _____

_____

Any significant family health conditions or problems (i.e. stroke, cancer, diabetes, allergies, etc.)

Please list _____

What is your reason for your child's visit today _____

_____

List any other health concerns _____

_____

FEE SCHEDULE

Fees vary depending on the treatment rendered. Patients will be charged the regular fee on the subsequent visit unless a discussion with your Chiropractor has determined that a more

involved combination of treatments will be beneficial for you and your health care goals.

CHIROPRATIC, ACUPUNCTURE OR LASER

PATIENT

Initial Examination		
Adult		**$ 100.00**
Children		**$ 80.00**
Regular Visit		
Adult		**$ 50.00**
Student	(Secondary and Post-Secondary School)	**$ 45.00**
Children	(Less than14yrs old)	**$ 40.00**
Intensive Visit (A minor addition of Acupuncture, Chiropractic or Laser)		
Adult		**$ 60.00**
Student		**$ 55.00**
Child		**$ 50.00**
Combination Visit (An additional full treatment of Acupuncture, Chiropractic or Laser)		
Adult		**$ 85.00**
Student		**$ 80.00**
Child		**$ 75.00**
MISSED VISIT**		**$ 30.00**
ORTHOTICS		**$ 500.00**
ORTHOPEDIC SHOES		**$ 230.00**

Payment is due at time service is rendered.
We accept cash, cheque, debit, MasterCard and VISA.

Chiropractic, Acupuncture and Laser are covered under Workplace Safety and Insurance Board, Motor Vehicle Accident Insurance and many Extended Health Care Plans. Any fees not accepted by the above are the patient's sole responsibility to pay.

**** Cancellations must be made 24 hours prior to your appointment time ****

I have read, understood and answered the above information to the best of my knowledge.

Signature _____ Date _____

PATIENT HISTORY

Dx Code: _____

Chief Complaint_____

Onset Acute/Chronic/Insidious/Recurrent:

_____

_____

_____

_____

_____

_____

_____

Prior Occurrence:

_____

_____

_____

Previous Therapy (X-rays):

_____

_____

_____

Character/Intensity:

_____

Frequency/ Duration_____

Aggravating:

_____

Relieving:

_____

Radiations_____

_____

Associated Symptoms:

_____

Exercise/ Lifestyle:_____

Personal Medical History:

_____

Family Medical History:

_____

Other Complaints:_____

_

_____

_____

_____

_____

_____

_____

_____

DX:_____

_____

_____ Px:

_____

PHYSICAL EXAMINATION

Posture: R.O.M.

Sensory: _____

Motor: _____ C0
Reflex:_____ C1
Orthopedic: C2
_____ C3
_____ C4
_____ C5
_____ C6
_____ C7
_____ T1
_____ T2
_____ T3
_____ T4
_____ T5
_____ T6
_ T7
_____ T8
Palpation:_____ T9
_____ T10
_____ T11
_____ T12
_____ L1
_____ L2
_____ L3
_____ L4
Radiological Examination: L5
_____ S1
S2
Initial Treatment: Report of Findings. S3
S4
S5
C0

PATIENT PRIVACY CONSENT FORM

The privacy of your personal information is an important part of our office providing you with top quality health care. We understand the importa of
protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as
open as possible about the way we handle your personal information. It is important to us to provide this service to our patients.
In this office, Dr. Barbara Ellis D.C. acts as the Privacy Information Officer.
All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us.
They are all trained in the appropriate uses and protection of your information.
In this consent form, we have outlined what our office is doing to ensure that:

1) Only necessary information is collected;
2) We only share your information with your consent;
3) Storage, retention and destruction comply with existing legislation and privacy protection protocols;
4) Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with any member of our staff.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here
how our office is using and disclosing your information.
This office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services in relationship to the musculoskeletal system
- to communicate with other treating health-care providers
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the OCA/CCA in a timely fashion,

when required, according to the provisions of the *Regulated Health Professions Act*
- to permit potential purchasers, practice brokers or advisors to evaluate the practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare material for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and /or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the *Regulated Health Professions Act (RHPA)* for the purposes of the Ontario Chiropractic Association fulfilling its mandate under RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will
forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy code, and I can ask to see the Code at any time.

I agree that the Westney Heights Chiropractic Centre can collect, use and disclose personal information about myself as set out above in the information
about the office's privacy policies.

Print _____ Sign _____ Date _____

Westney Heights Chiropractic Centre

Dr. Karen Martindale-Sliz BSc, DC / Dr. David Surette BPHE, BEd, DC

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 with 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)

_____ Date: _____ 20___