Clear Form

Help

BURNABYHEIGHTS INTEGRATIVE HEALTHCARE INC.

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Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

I. Patient Information

Name_____ Date_____
First MI Last
Address_____

City _____Province _____ Postal Code_____
Phone#: Home_____ Cell_____ Work_____
Do you prefer to receive calls at: ☐Home ☐Work ☐ Either
Email Address_____
Marital Status ☐Single ☐Married ☐Divorced/Separated ☐Widowed ☐Common-Law
Birth Date_____ Age_____ BC Care Card#_____
Children's Names and Ages _____
Contact person in case of emergency_____ Phone#_____

Occupation_____
Employer/Place of Work_____
Address_____ City_____ Province_____
Phone_____
How did you hear about our clinic?
☐Friend ☐Phone Book ☐Sign ☐Other_____

Do you have extended health insurance? ☐Yes ☐No
If yes, Extended Health Care Company:_____

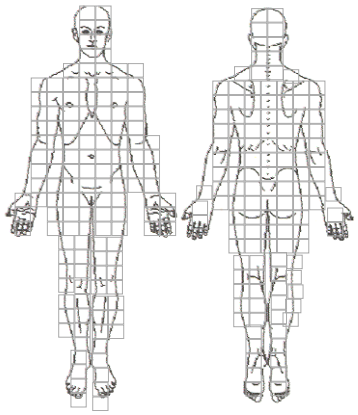
Have you seen a chiropractor previously? ☐Yes ☐No
Name_____ Date_____
Reason for past chiropractic care:_____
Results: ☐Excellent ☐Good ☐Fair ☐Poor

Medical Doctor_____
Telephone_____
Address_____
Date of last physical exam_____

II. Current Condition

Reason for this visit_____

On the diagram, please label the areas that are bothering you



Date symptoms began_____

What was the cause? (if known)_____

Is this visit today the result of: An Auto injury? □Yes □No
A work related injury? □Yes □No

**If yes, please ask the receptionist for additional paperwork for ICBC or WorksafeBC

Have you had a similar condition in the past?_____

Please describe the pain_____

How often does the pain occur?_____

What makes your problem better?_____

What makes your problem worse?_____

Is this condition getting progressively worse? □Yes □No

Describe the frequency of symptoms: □Constant □Comes and goes

Is this condition interfering with:
□Work □Sleep □Daily routine □Sports/exercise routine
□Other(please describe)_____

Other health care practitioners seen for this condition:
□Medical Doctor □Naturopathic Physician □Physical Therapist
□Registered Massage therapist □Other_____

III. Health Information

Are you currently taking any medications? □Yes □No
If yes, please list them:_____
_____

Are you currently taking any vitamins and supplements? □Yes □No
_____

Have you ever had any serious illness/surgeries or been hospitalized? If so, please list details:

_____

List all serious trauma, accidents, or injuries _____
_____

Please list any X-rays with dates when they were taken
_____
_____

Please list any allergies
_____

Do you wear: □Arch supports or orthotics □Heel lifts

Is there a family history of any of the following?

	Heart Disease	Arthritis	Cancer	Diabetes	Autoimmune conditions	Other (please list)
Father's Side	□	□	□	□	□	□
Mother's Side	□	□	□	□	□	□

(Females only)
Are you pregnant? □Yes □No
Do you have any problems with your menstrual cycle?
_____
Have you reached menopause?____ Surgical or physiological?_____

Have you had a Mammogram? □Yes □No
If yes, when was it performed? _____
What were the results?_____

Are you currently, or have you in the past, been on hormone replacement therapy? □Yes □No
Are you currently taking oral contraceptives? □Yes □No
Have you had a bone mineral density test? □Yes □No
If yes, when was it performed and what were the results?_____

IV. Personal/ Social History

Do you participate in a regular exercise program? If yes, what type of activity and how many hours per week?_____
What other interests/ hobbies do you enjoy?_____
Do you eat a balanced diet?_____ Describe_____
Do you get enough sleep?_____If no, is it due to pain?_____How many hours?_____
Have there been any changes in your bowel or bladder habits?_____
Do you smoke? □Yes □No If yes, how many cigarettes per day?_____ For how long?_____
Have there been any significant stressors in your life lately?_____
How do you handle stress?_____Has this changed recently?_____

V. Health History

Have you ever experienced or been diagnosed with any of the following? Please circle those which apply.

Alcoholism	Diarrhea or constipation	Heart Disease	Numbness or tingling	Sinus conditions
Anemia	Diabetes	Herniated Disc	Osteoporosis	Sleep disturbance
Anorexia or Bulimia	Difficulty hearing	Herpes	Overall weakness	Small Pox
Appendicitis	Difficulty walking	High Cholesterol	Pacemaker	Sore throat
Arm pain	Digestive disorders	Irregular heartbeat	Pain between shoulders	Spinal injury
Arthritis	Dizziness or Fainting	Jaw pain	Parkinson's Disease	Stroke
Asthma/allergies	Eczema	Joint pain/stiffness	Pinched Nerve	Suicide Attempt
Back pain	Emphysema	Kidney condition	Pleurisy	Swollen ankles
Black/bloody stool	Epilepsy	Liver Disease	Pneumonia	Thyroid Problems
Bladder problems	Excessive thirst	Low back pain	Polio	Tonsillitis
Bleeding Disorders	Fatigue	Lung disease	Poor or excessive appetite	Tuberculosis
Breast Lump	Forgetfulness	Measles	Productive cough	Tumors, Growths
Bronchitis	Fractures	Mental disorders	Prostate Problems	Typhoid Fever
Cancer	Frequent nausea	Miscarriage	Prosthesis	Ulcers
Cataracts	Gain or loss of weight	Mononucleosis	Psoriasis	Vaginal Infections
Chemical Dependency	Glaucoma	Multiple Sclerosis	Psychiatric Care	Venereal Disease
Chicken Pox	Gonorrhea	Mumps	Rheumatic Fever	Vision problems
Chronic infection	Gout	Neck pain	Rheumatoid Arthritis	Vomiting
Convulsions	Headaches	Night sweats	Shortness of breath	Whooping Cough
Depression				

Do you have a history of high blood pressure? □Yes □No
Is there anything else the doctor should know about your health?

_____
_____
_____
_____
_____

VI. Office Payment Policies

As posted, our fees are as follows:

Initial Visit (Examination and 1st treatment)	$80
Second visit/Report of Findings	$60
Subsequent visits	$50
Extended Visit: Intended for Acute Situations requiring additional care or a closer examination of two or more areas	$80

Your appointment time is reserved for you. Please note that to cancel or reschedule your appointment, a minimum of 24 hours notice is required to avoid a late cancellation fee of $25.

VII. Coverage for Chiropractic Treatment

Claims for Worksafe BC, the Insurance Corporation of British Columbia, and private insurance carriers may cover part or all of your treatment expenses.

If your Worksafe BC claim is accepted, we will reimburse to you for the payments we receive from Worksafe BC. If for any reason, WCB does not accept your claim, you are responsible for all charges related to the treatment.

The Insurance Corporation of British Columbia will pay you directly for a portion of your treatment costs. A cheque will be mailed to your home address.

To receive reimbursement from private insurance carriers, mail the required claim form along with your receipt for treatment to the insurance company.

VIII. Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I have read the above and I accept full responsibility for payment of chiropractic treatment fees.

_____

Signature of Patient (or parent of a minor) Date

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
Informed Consent to Chiropractic Treatment FORM – L

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

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;

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. Research studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, the stroke is already in progress. However, you are being informed of this reported association because a stroke may causes serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

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 chiropractic treatment.

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 treatments recommended to me by my chiropractor, including any recommended spinal adjustment.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____	_____
Patient Signature (Legal Guardian)	**Witness of Signature**
Name:_____	**Name:_____**
(please print)	**(please print)**

CCPA.06.05