



**Why this form is important** – As a family wellness-oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate & eliminate any & all interference to the full outward expression of that potential & address the issues that brought you here. Most times, the effects are so gradual that they are not felt until they become serious, & sometimes not until it's too late! In addition, we hope to offer you & your family the opportunity for a **lifetime** of health, happiness & vitality.

Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to

**PERSONAL AND FAMILY HEALTH HISTORY**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_ (Age \_\_\_\_\_)

Address: \_\_\_\_\_ Sex:  F  M BC Health Card #: \_\_\_\_\_

City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal: \_\_\_\_\_ Are you or might you be pregnant?  Yes  No

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Occupation: \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Names of children (ages): \_\_\_\_\_

**GROWTH & DEVELOPMENT**

**Did you ever...**

Have any serious falls or accidents? Y / N \_\_\_\_\_

Have recurrent childhood illness/sickness? Y / N \_\_\_\_\_

Experience other serious traumas/stress? Y / N \_\_\_\_\_

**CURRENT HEALTH HABITS**

**Do you...**

Eat healthy foods regularly? Y / N \_\_\_\_\_

Drink 8-10 cups of water daily? Y / N \_\_\_\_\_

Exercise regularly? Y / N \_\_\_\_\_

Smoke? Y / N \_\_\_\_\_

Have high mental stress? Y / N \_\_\_\_\_

Have high physical stress? Y / N \_\_\_\_\_

Have any serious or chronic past injuries? Y / N \_\_\_\_\_

Have sleeping problems? Y / N \_\_\_\_\_

Sleeping position: side; stomach; back \_\_\_\_\_

Have you been in car accidents? Y / N \_\_\_\_\_ When? \_\_\_\_\_

**Was Your Birth Traumatic?**  
(Circle if you know...)

Long delivery?..... Y / N

Difficult delivery?..... Y / N

Forceps/vacuum extractor?.. Y / N

Caesarian section?..... Y / N

Breech/cephalic? ..... Y / N

Mother given drugs/  
epidural during birth?..... Y / N

Induced labour?..... Y / N

**FAMILY HEALTH PROFILE** – Please mark if you have a family history of:

	Arthritis	Cancer	Diabetes	Heart Disease	High Blood Pressure	Strokes	Other _____
Your father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Your mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Your children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**MEDICAL INFO:**

Who is your medical doctor? \_\_\_\_\_

If you are taking medications, please list them.

Med: \_\_\_\_\_ For what? \_\_\_\_\_ For how long? \_\_\_\_\_

Med: \_\_\_\_\_ For what? \_\_\_\_\_ For how long? \_\_\_\_\_

Med: \_\_\_\_\_ For what? \_\_\_\_\_ For how long? \_\_\_\_\_

Other: \_\_\_\_\_

What side effects have you experienced from the drugs &/or surgery?

\_\_\_\_\_

\_\_\_\_\_

If you have had any surgeries, please list them.

Surgery: \_\_\_\_\_ For what? \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ For what? \_\_\_\_\_ Date: \_\_\_\_\_

Surgery: \_\_\_\_\_ For what? \_\_\_\_\_ Date: \_\_\_\_\_

## ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Have you been to a chiropractor before?    Y / N                      If yes, who have you seen? \_\_\_\_\_  
 If yes, for what? \_\_\_\_\_                      When was your last adjustment? \_\_\_\_\_

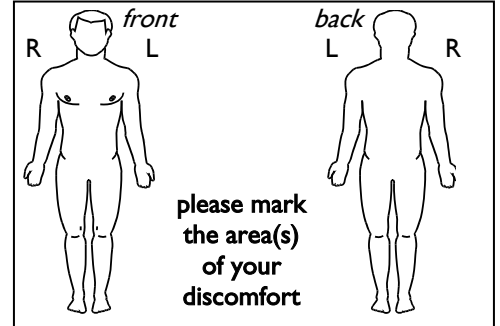
\*\*\* If you have no symptoms or complaints and you are here for wellness care, please check here:  
 *I wish to have Chiropractic Wellness Services*  
 & skip to the **CURRENT SYMPTOMS** section near the bottom of this form. Otherwise, please continue.

Present Complaint (Reason for your visit today):  
 \_\_\_\_\_  
 \_\_\_\_\_

Pain or problem started how and when? \_\_\_\_\_  
 \_\_\_\_\_

What activities make your condition / pain worse? \_\_\_\_\_  
 \_\_\_\_\_

What activities make your condition / pain better? \_\_\_\_\_  
 \_\_\_\_\_



If you have pain, is it...     sharp     dull     radiating     constant     intermittent  
     mild     moderate     mod-severe     severe

Since it began, is it...     the same     variable     getting better     getting worse

What time of day is worst?     waking     at work     evening  
     at night     variable     constant

Does it interfere with...     work     sleep     walking  
     sitting     exercise     other \_\_\_\_\_

Are there other doctors / treatments that you have tried for this problem? (Please list.)

massage therapist \_\_\_\_\_     physiotherapist \_\_\_\_\_  
 acupuncturist \_\_\_\_\_     medical doctor \_\_\_\_\_  
 other \_\_\_\_\_

### OTHER TESTS: (please circle)

Have you ever had:  
 X-rays / CT scan / MRI  
 of your :  
 Neck / Back / Hips/pelvis

If yes, how long ago?  
 <7 years, > 7yrs

Do you remember what the  
 results were? \_\_\_\_\_

### **CURRENT SYMPTOMS** (even if they do not seem related to your current condition):

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> headaches / migraines     | <input type="checkbox"/> dizziness / vertigo        | <input type="checkbox"/> sinus problems / allergies | <input type="checkbox"/> high blood pressure       |
| <input type="checkbox"/> neck stiffness / pain     | <input type="checkbox"/> fatigue                    | <input type="checkbox"/> shortness of breath        | <input type="checkbox"/> heart problems / stroke   |
| <input type="checkbox"/> shoulder stiffness / pain | <input type="checkbox"/> sleeping problems          | <input type="checkbox"/> constipation / diarrhea    | <input type="checkbox"/> cancer                    |
| <input type="checkbox"/> pins & needles in arms    | <input type="checkbox"/> tension / stress           | <input type="checkbox"/> problems urinating         | <input type="checkbox"/> diabetes                  |
| <input type="checkbox"/> numbness in fingers       | <input type="checkbox"/> nervousness / anxiety      | <input type="checkbox"/> cold sweats                | <input type="checkbox"/> recurring infection       |
| <input type="checkbox"/> back stiffness / pain     | <input type="checkbox"/> irritability / mood swings | <input type="checkbox"/> hot flashes                | <input type="checkbox"/> loss of smell / taste     |
| <input type="checkbox"/> pins & needles in legs    | <input type="checkbox"/> depression                 | <input type="checkbox"/> menopause                  | <input type="checkbox"/> vision changes            |
| <input type="checkbox"/> numbness in feet / toes   | <input type="checkbox"/> stomach upset              | <input type="checkbox"/> PMS / menstrual cramps     | <input type="checkbox"/> buzzing / ringing in ears |
| <input type="checkbox"/> foot problems             | <input type="checkbox"/> heartburn / reflux         | <input type="checkbox"/> infertility / impotence    | <input type="checkbox"/> loss of balance           |
| <input type="checkbox"/> jaw / TMJ problems        | <input type="checkbox"/> ulcers                     | <input type="checkbox"/> cold hands / feet          | <input type="checkbox"/> chest pains               |
| <input type="checkbox"/> other _____               |   |   |  |

### **RESULTS:**

*As a result of my chiropractic care, I would like to: (Please check all that apply)*

- Feel better quickly*                       *Live a healthier lifestyle*  
 *Have a healthier spine*               *Learn about a healthier lifestyle*  
 *Have a healthier body by keeping my nerve system healthy*

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

On a daily basis, we all experience physical, chemical, & emotional stresses that can accumulate & result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, & sometimes not until it is too late!  
 At PITT MEADOWS WELLNESS CENTRE, we will help to find & treat the cause of these effects.  
**Chiropractic** helps your entire body – for a healthier life & spine!

# PITT MEADOWS WELLNESS CENTRE



*...experience life!*

## OFFICE FEE SCHEDULE & FINANCIAL POLICY

(fees subject to change with 30 days posted notice)

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◆ Consultation .....	No Charge	◆ Chiropractic Adjustment .....	\$40
◆ Initial Examination .....	\$60	Children 18 & under .....	\$30
◆ Progressive Examination .....	\$40	◆ Family Care Plan .....	on individual basis
		◆ Wellness Care Plan .....	on individual basis

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We are committed to providing you the best Chiropractic care possible in a caring environment & have established our financial policies to achieve that goal. You will be expected to pay for your Chiropractic care at the time the service is rendered.

### Automobile Collision or Work Injury

If your health problem is the result of a MOTOR VEHICLE ACCIDENT or if it is a WORK INJURY, please notify our office manager. If we accept your case, we must receive approval from ICBC or WCB for Chiropractic adjustments. Until that time, you will be expected to pay in full for your Chiropractic care at the time the service is rendered. Upon approval, you will be refunded any extra monies paid.

### Health Insurance

As of January 1, 2002, the Medical Services Plan of British Columbia no longer provides coverage for Chiropractic care. However, most extended health plans do provide coverage for Chiropractic care. If you have insurance that covers Chiropractic, we will give you all of the information you need to help you get reimbursed quickly.

We have found it is easier, for your record keeping, & ours, if we give you receipts at the end of your first visit & then once a month after that. Just send in your receipts to your insurance company with a copy of your claim form & they will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you & them.

### CANCELLATION POLICY

Please keep your appointment! If you cannot keep your appointment, please respect our office's cancellation policy by providing a minimum of 3 hours notice for all cancellations. A missed appointment is one that might have been used by another patient. Late or missed appointments are your responsibility, & **may** result in a \$25.00 missed appointment fee being charged to you personally.

◆ ALL FEES ARE TO BE PAID AT THE TIME OF SERVICE ◆  
◆ WE ACCEPT CASH, CHEQUE, DEBIT AND CREDIT CARDS ◆

I am ultimately responsible for all of my charges at this office, regardless of insurance coverage.

*I have read, understand, and agree to this financial policy.*

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# PITT MEADOWS WELLNESS CENTRE



*...experience life!*

## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

*\* This is NOT a waiver \**

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) *While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques;*
- b) *There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote;*
- c) *There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.*

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**HEALTH:** A state of optimal physical, mental and social well-being; not merely the absence of disease.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our chiropractic method is by specific adjustments of the spine and other joints.

**SUBLUXATION:** A misalignment or restriction of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This results in a lessening of the body's innate ability to express its maximum health potential. Subluxations may also occur in other joints in the body.

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**OUR MAIN OBJECTIVE, and the goal of chiropractic, is to eliminate interference to the expression of the body's innate intelligence and its healing potential. Our method uses specific adjustments to correct subluxations.**

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor, Dr. Jason Casey and/or Dr. Sandra Lohman, the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

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PRINT NAME

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SIGNATURE OF PATIENT  
(OR PARENT OR GUARDIAN)

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DATE

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WITNESS TO SIGNATURE ABOVE