Hamilton Back Clinic

Intake Form

Name: _____ Address: _____

City: _____ Postal Code: _____

Phone: _____ Sex: _____ Date of Birth: _____
Month/Day/Year

E-mail: _____

Emergency Contact: Name/Phone: _____

Name of Family Physician (MD): _____

Employer: _____ Employer Phone: _____

Name of Extended Health Insurance Co: _____

Please indicate what your coverage includes:

☐ Chiropractic ☐ Acupuncture

☐ Physiotherapy ☐ Foot Orthotics ☐ Don't Know

Who may we thank for referring you? _____

Reason for Visit: _____ When did this occur: _____

Due to auto/work injury?: _____

How would you describe the pain?: _____

Is pain constant? _____ Does pain travel? _____ Where? _____

What makes it worse? ☐ Sitting ☐ Walking ☐ Bending ☐ Other

What makes it better? ☐ Ice ☐ Heat ☐ Rest ☐ Exercise ☐ Meds

What medications are you currently taking?: _____

Any previous trauma (fall, accident) _____

Any previous surgeries? _____

Any food / drug allergies? _____

Have you seen any other doctors for this condition? _____

Medical History

Please check off the box if you have a **family history** of the following:

- ☐ Cancer
  Type:_____
- ☐ Heart Disease
- ☐ Diabetes
- ☐ At the best of my knowledge I am pregnant
- ☐ At the best of my knowledge I am not pregnant
- ☐ Lung Disease
- ☐ High Cholesterol / Blood Pressure
- ☐ Thyroid Disease

* Should you become pregnant please advise the doctor at your next visit.

Please check off the box if you have had or currently suffer from the following:

- ☐ AIDS/ HIV
- ☐ ANAEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ANOREXIA
- ☐ APPENDICITIS
- ☐ BLEEDING DISORDERS
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ BOWEL DISEASE
- ☐ BULIMIA
- ☐ CANCER
- ☐ EARACHES
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FRACTURES
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEADACHES
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HIGH CHOLESTEROL/ BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BACK PAIN
- ☐ LUNG DISEASE
- ☐ MUMPS
- ☐ MONONUCLEOSIS
- ☐ MULTIPLE SCLEROSIS
- ☐ MUSCULAR DISEASE
- ☐ MENTAL DISEASE
- ☐ MIGRAINES
- ☐ NECK PAIN
- ☐ OSTEOPOROSIS
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTHESIS
- ☐ RHEUMATIC FEVER
- ☐ PACEMAKER
- ☐ SCARLET FEVER
- ☐ SORE MUSCLES
- ☐ STROKE
- ☐ STD'S
- ☐ SKIN DISORDERS
- ☐ TENDONITIS
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ TUMOURS
- ☐ ULCERS
- ☐ OTHER

_____
_____
_____
_____
_____
_____

The information I have given in both the patient history and medical history are correct to the best of my knowledge.

_____ _____

Signature Date

PAYMENT SCHEDULE

Chiropractic/Acupuncture

Initial Visit

(Standard) $85

Standard Visit

$52

Standard Visit with Medical Acupuncture

(Standard) $52

Laser Therapy

$52

Physiotherapy

Initial Visit $85

Follow Up Visit $62

** I understand payment is due on the same day that I have been treated.

_____ _____

Patient Signature Date

MISSED APPOINTMENTS

If you must cancel an appointment, we require that you notify us 6 hours prior to your scheduled appointment. There will be a **$15.00 fee** for a missed appointment.

Informed Consent to Chiropractic/ Physiotherapy Treatment

There are risks and possible risks 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. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in early stage of a stroke. In essence, there is a stroke in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.
C. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments of other 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/physiotherapist.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss with my chiropractor/physiotherapist the nature and purpose of chiropractic/physiotherapy 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/physiotherapy treatment recommended to me by my chiropractor/physiotherapist including any recommended spinal adjustments.

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

Dated this _____ day of _____, 20_____

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

Name: _____ Name: _____

Informed Consent for Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxabustion, cupping, guasha, laser, electro acupuncture and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the acupuncturist or another duly authorized person in the clinic.

I have had the opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedure. I understand that results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and am informed that, as with all health care, the practice of acupuncture poses slight risks from treatment, including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, lung injury, infection and shock. I don't not expect acupuncturists to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgement during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dated this _____ day of _____, 20_____

_____ _____

Patient Signature Witness of Signature

Name: _____ Name: _____

(Please Print) (Please Print)