



Welcome! It is our mission to help as many families as we can achieve and maintain their optimal health potential. Please complete these forms in full.

Patient Introduction

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: H:() _____ W:() _____ ext: _____ C:() _____
Birth Date: _____ Spouse: _____
Kids (circle): Yes No Names and Ages: _____
Your Occupation: _____ Employer: _____
Previous Chiropractor: _____ Present MD: _____
Whom shall we thank for referring you to our office? _____
Reason for consulting our office today? _____
Email Address (for important office announcements - hour changes, closures, holiday schedule, etc...no SPAM, we promise): _____ @ _____

Current Health Profile

Your Main Complaint: _____
Any other Complaints: _____
How long have you suffered with this problem? _____
What makes this problem worse? _____ Better? _____
What is the pattern of this problem? Constant ___ Occasional ___ Intermittent ___
How did it start? _____
Do you experience pain at night? Y N Night sweats? Y N Unexplained weight loss? Y N
If you are experiencing pain, is it: dull sharp pins/needles travels constant comes/goes
Does it interfere with: work sleep walking sitting hobbies leisure
Names of other doctors seen for this problem: _____

Health History

Do you smoke? Y N How many Years? _____ # Packs/day? _____
Are you on any type of medication? _____ Please list all: _____

Any surgeries? _____
My past health history has been (circle): poor ok good very good excellent
I suffer from (circle): *high cholesterol diabetes cancer osteoporosis arthritis high blood pressure other*
Have you been involved in an auto accident? _____ Date of accident: _____

Please think of past traumas in your life (minor car accidents, falls, traumatic birth, sports injury, falls as a child, etc...) It is important that you complete this as best as you can.

1. _____
2. _____
3. _____
4. _____
5. _____

Please check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbing-Tingling in Hands/Feet | <input type="checkbox"/> Asthma/allergies |
| <input type="checkbox"/> Pain Between Shoulders B | <input type="checkbox"/> Numbing-Tingling in Arms/Legs | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Foot /Ankle Pain |
| <input type="checkbox"/> Tired / Fatigued | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Tight Muscles | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Tension across shoulders | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> depression | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Miscarriage(s) | <input type="checkbox"/> Allergies / Sinus Problems | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Liver/gall bladder problems | <input type="checkbox"/> Diarrhea / Constipation | <input type="checkbox"/> Walking problems |
| <input type="checkbox"/> High blood pressure | | <input type="checkbox"/> Confusion |
| | | <input type="checkbox"/> Balance problem |

I participate in/do: computer work sports prolonged postures sleep face down
Please rate your level of commitment to resolving your problem(s)(10 being the highest): _____

Family Health Profile

In order to detect any patterns in your family history, please mention any conditions any of your family members suffer from.

Children: _____

Spouse: _____

Mother/Father: _____

Brother(s)/Sister(s): _____

Others: _____

For Women Only

Are you pregnant? _____

Date of your last menstrual period: _____

Are you using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	\$ 60.00
Radiology (if required)	\$ 60.00
Report of Findings	Complimentary

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: _____ Date: _____

(Signature of parent/guardian required if patient under age 18)

Office use only: Health Pass Received

Your Informed Consent

Although Chiropractic is reported to be one of the safest health care systems in the world, there may be slight risks associated with it. We feel that it is responsible to let you know:

- 1) The risk of stroke has been reported to be approximately 1 in a million. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjusting and the occurrence of stroke;
- 2) While extremely rare, some patients may experience short term aggravation of symptoms; there have been reports of ligament sprains and rib fractures;
- 3) There have been rare reports of disc injuries although no scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both clinically and cost effective. The risk of injuries and complications is so small that chiropractors carry one of the lowest malpractice insurance premiums of all the health care professions. Chiropractic care contributes to your overall well being. Compared to traditional medical/drug/surgical care, Chiropractic is one of your safest health care systems.

Chiropractic is not a treatment for any disease or condition, but a healing art that removes interference to your healing capabilities. Our focus is primarily removing interference to your nervous system through chiropractic adjustments.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the examination and care recommended by my chiropractor and extend this consent to include all doctors of this facility. I intend this consent to apply to all present and future care for myself and my family.

Dated this _____ Day of _____, 20_____.

Patient Name (please print)

Patient Signature (Legal Guardian)

Name of Witness (please print)

Witness Signature

Privacy Policy (this document is a summary of our privacy policy)

Privacy and sensitivity of personal health information is an important principle in the office of Dr. Jonathan Saunders. We are committed to collecting, using and disclosing personal health information responsibly and confidentially and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle health information.

This office will collect, use and disclose information for the following purposes: access your health care needs and advise of your options. This may include consultation, examination, diagnosis/differential diagnosis, prognosis, recommendations and referral; obtain a baseline of health and social information; establish credit or goods/services and properly invoice;

Personal health information includes information that relates to your personal characteristics, health or activities and views. Personal health information is to be contrasted with publicly available information and business information, which is not protected by privacy legislation.

Dr. Jonathan Saunders will protect personal health information, by security safeguards appropriate to the sensitivity of the information. Safeguards will vary depending on the sensitivity, format (paper/electronic) and storage of the personal health information.

We need to retain personal health information for some time to ensure that we can answer any questions you might have about the services provided and for our own accountability to external regulatory bodies. However, we do not want to keep personal health information too long in order to protect your privacy.

Personal health information can only be used or disclosed for the purpose for which it was obtained. In most cases, we shall ask an individual to specifically consent in writing, but in some circumstances, we may accept your verbal consent with/without documentation. Under certain circumstances, we will use and disclose personal health information without consent for example in the case of medical emergency. Subject to certain legal, contractual resolutions and reasonable notice, you may withdraw your consent at any time.

Access to summary of an individual's personal health information held by Dr. Jonathan Saunders is available upon request. We can help you identify what records we might have about you. If we can not give you access, we will tell you within 30 days if at all possible and tell you the reason and possible recourse that is available. If you believe there is a mistake in the information, you have the right to ask for it to be corrected.

SIGNATURE: _____

DATE: _____