

# WELCOME to ROYAL YORK CHIROPRACTIC !

To ensure your visit with us is a pleasant one, here are the procedures you can expect during your visit.

- PAPERWORK:** Kindly complete this questionnaire. The doctor will use this to formulate his recommendations for your care.
- CONSULTATION:** You will meet the Doctor and his technical assistant(s). The Doctor will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.
- EXAMINATION:** Standard physical, orthopaedic, neurological and chiropractic testing, including computerized scanning, will be performed to determine the cause(s) of your health problems and subluxations.
- SPINAL IMAGES:** Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathologies and make your chiropractic care more precise.

## CONFIDENTIAL PATIENT CASE HISTORY

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_ ext: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Mobile / Pager: \_\_\_\_\_

Email Address: \_\_\_\_\_

*In order to conserve paper, we prefer to communicate office information and newsletters primarily by email. We will not share your email address with any 3rd party.*

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
day month year

Employer Name and Address: \_\_\_\_\_

Are you pregnant ? yes  no  Due Date: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Marital Status: single  married  separated  divorced  widowed

Names and Ages of Children: \_\_\_\_\_

Name and Telephone of Medical Doctor: \_\_\_\_\_

Whom may we thank for referring you ? \_\_\_\_\_

Have you had previous CHIROPRACTIC ? \_\_\_\_\_ when? Name of previous CHIROPRACTOR: \_\_\_\_\_

Do you have extended health insurance? yes  no  Annual value of health insurance for chiropractic: \$ \_\_\_\_\_

Annual value of health insurance for foot orthotics: \$ \_\_\_\_\_

Reason for today's visit : \_\_\_\_\_

**Thanks! Please turn over the page.**

**SOURCES of SPINAL STRESS that CAUSE SUBLUXATIONS**

To help us determine the exact cause of your problem, please indicate on this page any potential sources of spinal trauma.

**1. BIRTH TRAUMA** - with respect to your own birth process, please check all that apply:

- |                                            |                                                                    |                                                                                   |
|--------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Natural           | <input type="checkbox"/> Epidural / Drug Induced                   | <input type="checkbox"/> Not Sure                                                 |
| <input type="checkbox"/> Premature         | <input type="checkbox"/> C-Section                                 | Did <u>your mother</u> sustain any falls, accidents or injuries during pregnancy? |
| <input type="checkbox"/> Breech            | <input type="checkbox"/> Cord around Neck                          |                                                                                   |
| <input type="checkbox"/> Forceps           | <input type="checkbox"/> Prolonged Delivery                        |                                                                                   |
| <input type="checkbox"/> Vacuum Extraction | <input type="checkbox"/> Pulling / Twisting by the Delivery Doctor |                                                                                   |
|                                            |                                                                    |                                                                                   |
|                                            |                                                                    | <input type="checkbox"/> Yes                                                      |
|                                            |                                                                    | <input type="checkbox"/> No                                                       |
|                                            |                                                                    | <input type="checkbox"/> Not Sure                                                 |

**2. CHILDHOOD ACCIDENTS / INJURIES** - please **check** all that apply:

- |                                                             |                                                               |
|-------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Fell down _____ Injuries: _____    | <input type="checkbox"/> Sports Injury _____ Injuries: _____  |
| <input type="checkbox"/> Car Accident _____ Injuries: _____ | <input type="checkbox"/> Physical Fight _____ Injuries: _____ |
| <input type="checkbox"/> Car Accident _____ Injuries: _____ | <input type="checkbox"/> Other _____ Injuries: _____          |
| <input type="checkbox"/> Other _____ Injuries: _____        |                                                               |

**3. ADULT ACCIDENTS / INJURIES** - please **check** all that apply:

- |                                                             |                                                               |
|-------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Fell down _____ Injuries: _____    | <input type="checkbox"/> Sports Injury _____ Injuries: _____  |
| <input type="checkbox"/> Car Accident _____ Injuries: _____ | <input type="checkbox"/> Physical Fight _____ Injuries: _____ |
| <input type="checkbox"/> Car Accident _____ Injuries: _____ | <input type="checkbox"/> Other _____ Injuries: _____          |
| <input type="checkbox"/> Other _____ Injuries: _____        |                                                               |

**4. HOSPITALIZATIONS, OPERATIONS and ILLNESSES** - please list all details and approximate dates:

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**5. Please list any medication (prescription or over-the-counter) that you have taken in the past 6 months and list how often:**

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*Thanks! Please go to the next page.*

6. **AUTOMOBILE ACCIDENTS** - have you ever, even as a passenger, been involved in a car accident or near collision? (even if you think you were not hurt)  Yes  No

If you answered **YES to question 6**, please complete the following:

Accident Date: \_\_\_\_\_

Accident Date: \_\_\_\_\_

Description of Accident: \_\_\_\_\_

Description of Accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Speed of Collision \_\_\_\_\_

Speed of Collision \_\_\_\_\_

Severity of Damage: \_\_\_\_\_

Severity of Damage: \_\_\_\_\_

Injury after Accident: \_\_\_\_\_

Injury after Accident: \_\_\_\_\_

Who Examined You: \_\_\_\_\_

Who Examined You: \_\_\_\_\_

X-Rays Taken: \_\_\_\_\_

X-Rays Taken: \_\_\_\_\_

Did you see a Chiropractor?  Yes  No

Did you see a Chiropractor?  Yes  No

7. **Primary Daily Activities - constant poor posture will lead to spinal stress and subluxations.**

Sitting \_\_\_\_\_  
hours per day

Walking \_\_\_\_\_  
hours per day

Telephone \_\_\_\_\_  
hours per day

Standing \_\_\_\_\_  
hours per day

Computer \_\_\_\_\_  
hours per day

Repetitive \_\_\_\_\_  
Work hours per day

Driving \_\_\_\_\_  
hours per day

Heavy \_\_\_\_\_  
Labour hours per day

Other \_\_\_\_\_

8. **Where is the location of your major complaint?**

Right  Left  Center  Both Sides  Upper  Lower

9. **How does this affect your life in general?** (example: physical activity, mood, work productivity, family life, etc.)

\_\_\_\_\_

10. **Spinal stress** can generate **different types of discomfort throughout the body.** Describe what you feel:

Burning

Diffuse

Dull / Aching

Sore

Stabbing

Tingling

Radiating

Throbbing

Sharp

Shooting

Localized

Other \_\_\_\_\_

**Thanks! Please turn over the page.**



## About Your Health ...

The human body is designed to be healthy. Throughout life, events occur which damage your expression of health . This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your report of findings your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate or inborn health potential.

### PRESENT HEALTH: Are you CURRENTLY affected by any of the following ? (please CIRCLE)

MUSCLE and JOINT	GENERAL SYMPTOMS	GASTROINTESTINAL	CARDIOVASCULAR	STRESS SYMPTOMS
Backache Neck pain Foot trouble Shoulder pain Hernia Spinal curvature Poor posture Arthritis	Fever / Chills / Sweats Fainting Convulsions Allergy Skin problems Colds Tremors Loss of balance	Difficult digestion Belching or gas Nausea or vomiting Stomach pain / heartburn Constipation Colon trouble Liver trouble Gall Bladder trouble Diarrhea Bloody stools	Rapid heart beat Slow heart beat High blood pressure Low blood pressure Chest pain Swelling of ankles Poor circulation	Headache / Migraine Dizziness Numbness / pins & needles Ringing in ears Loss of sleep Poor concentration Irritable / Nervousness Depression Decreased energy / fatigue Tension
RESPIRATORY	URINARY	E.E.N.T.	FEMALE ISSUES	
Chronic cough Spitting up phlegm / blood Chest pain Difficulty breathing	Painful urination Waking up at night - urinate Blood in urine Increased urination	Deafness Earache Sore throat Asthma Tonsillitis Sinus trouble	Painful menstruation Excessive flow Irregular menstruation Cramps or backache Abnormal discharge Date of last menstrual period: _____	Post menopause Birth Control Pill Number of miscarriages

### PAST HEALTH: Have you ever suffered from any of the following IN THE PAST ? (please CIRCLE)

Thyroid trouble Diabetes Tuberculosis Pneumonia Stomach ulcers Previous heart attack	Emotional problems Epileptic seizures Asthma Alcoholism Psoriasis Previous stroke	Polio Cancer Venereal Disease AIDS / HIV Other: _____
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### INFORMED CONSENT TO CHIROPRACTIC CARE and OFFICE POLICIES

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on me by Dr. Peter Hryciuk or anyone working in this clinic authorized by him. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures. I understand as in all health care that results are not guaranteed. I further understand and am informed that in the practice of chiropractic, as in all health care, there are some extremely rare risks to treatment, including, but not limited to; muscle strains, sprains, disc injury and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on his ability to exercise judgement during the course of the procedure which he feels at the time, based on the facts known, is in my best interest.

All outstanding balances are to be settled at the end of each week. In the event you would like to sign out any x-rays the fee is \$40. Chiropractic key fobs are the property of RYCC and the replacement cost is \$25. Missed appointments (no shows) are subject to a charge.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above mentioned chiropractic procedures. I intend this consent form to cover the entire course of treatment for any of the conditions which I may have.

TO BE COMPLETED BY PATIENT:

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
SIGNATURE (Patient or Guardian)

\_\_\_\_\_  
DATE