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 third party. By providing your email address, you consent to receiving periodic office information via email.

☐ Check here to get FREE text / email reminders for your future appointments.

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 ? __________ Name of previous CHIROPRACTOR: ______________________

when?

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 <u>exact cause</u> of your problem, please indicate on this page any potential sources of spinal trauma.

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

- [ ] Natural
- [ ] Premature
- [ ] Breech
- [ ] Forceps
- [ ] Vacuum Extraction
- [ ] Epidural / Drug Induced
- [ ] C-Section
- [ ] Cord around Neck
- [ ] Prolonged Delivery
- [ ] Pulling / Twisting by the Delivery Doctor
- [ ] Not Sure

Did **<u>your mother</u>** sustain any falls, accidents or injuries during pregnancy?

- [ ] Yes
- [ ] No
- [ ] Not Sure

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

- [ ] Fell down __________ Injuries: __________
- [ ] Car Accident ________ (date(s)) Injuries: _________
- [ ] Car Accident ________ (date(s)) Injuries: _________
- [ ] Other ______________ (date(s)) Injuries: _________
- [ ] Sports Injury __________ (date(s)) Injuries: __________
- [ ] Physical Fight ________ (date(s)) Injuries: _________
- [ ] Other ______________ (date(s)) Injuries: _________

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

- [ ] Fell down __________ Injuries: __________
- [ ] Car Accident ________ (date(s)) Injuries: _________
- [ ] Car Accident ________ (date(s)) Injuries: _________
- [ ] Other ______________ (date(s)) Injuries: _________
- [ ] Sports Injury __________ (date(s)) Injuries: __________
- [ ] Physical Fight ________ (date(s)) Injuries: _________
- [ ] Other ______________ (date(s)) Injuries: _________

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

____

____

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

____

____

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: _______________

Description of Accident: _____________________________

____

____

Speed of Collision ___________

Severity of Damage: _______________________________

Injury after Accident: _______________________________

Who Examined You: _______________________________

X-Rays Taken: ______________

Did you see a Chiropractor? ☐ Yes ☐ No

Accident Date: _______________

Description of Accident: _____________________________

____

____

Speed of Collision ___________

Severity of Damage: _______________________________

Injury after Accident: _______________________________

Who Examined You: _______________________________

X-Rays Taken: ______________

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

☐ Standing _________ hours per day

☐ Driving _________ hours per day

☐ Walking _________ hours per day

☐ Computer _________ hours per day

☐ Heavy Labour _________ hours per day

☐ Telephone _________ hours per day

☐ Repetitive Work ________ 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.

11. Spinal stress can also **choke the nerves, causing pain to travel to different parts of the body.** For example, neck pain can travel down the arms and back pain down the legs. Have you experienced any traveling pain?

☐ Yes ☐ No If **yes, pain travels from** ___________________ **to** ____________________
(please indicate side of body)

12. Spinal stress can put pressure **on the spinal cord and nerves,** causing symptoms to come and go over time. Is your condition **CONSTANT** or **INTERMITTENT?** (circle one)

13. Circle on a scale of 1-10 how you would rate your **discomfort:**

no pain moderate pain extreme pain

1 2 3 4 5 6 7 8 9 10

14. What have you found that **AGGRAVATES** your symptoms?

____

15. What have you found that **IMPROVES** your symptoms?

____

16. Who have you **already consulted** in an attempt to correct this problem? (eg. Chiropractor, massage therapist, physiotherapist)

____

17. What are you hoping to **improve in your life by using Chiropractic care?** If you were **feeling 100%** what **activity** would you like to **start doing or do more of?**

____

18. Circle on a scale of 1-10 how **COMMITTED you are to ACHIEVING OPTIMAL HEALTH:**

not committed moderately committed 100% committed

1 2 3 4 5 6 7 8 9 10

19. What is **most important to you** in a relationship with our office? (please check ***only one***)

☐ Time ☐ Trust / Honesty ☐ Communication ☐ Other ______________
☐ Finances ☐ Results ☐ Friendliness

Thanks! Please go to the next 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	Fever / Chills / Sweats	Difficult digestion	Rapid heart beat	Headache / Migraine
Neck pain	Fainting	Belching or gas	Slow heart beat	Dizziness
Foot trouble	Convulsions	Nausea or vomiting	High blood pressure	Numbness / pins & needles
Shoulder pain	Allergy	Stomach pain / heartburn	Low blood pressure	Ringing in ears
Hernia	Skin problems	Constipation	Chest pain	Loss of sleep
Spinal curvature	Colds	Colon trouble	Swelling of ankles	Poor concentration
Poor posture	Tremors	Liver trouble	Poor circulation	Irritable / Nervousness
Arthritis	Loss of balance	Gall Bladder trouble		Depression
		Diarrhea		Decreased energy / fatigue
		Bloody stools		Tension

RESPIRATORY	URINARY	E.E.N.T.	FEMALE ISSUES	
Chronic cough	Painful urination	Deafness	Painful menstruation	Post menopause
Spitting up phlegm / blood	Waking up at night - urinate	Earache	Excessive flow	Birth Control Pill
Chest pain	Blood in urine	Sore throat	Irregular menstruation	Number of miscarriages
Difficulty breathing	Increased urination	Asthma	Cramps or backache	
		Tonsillitis	Abnormal discharge	
		Sinus trouble	Date of last menstrual period: ____________________	

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

Thyroid trouble	Emotional problems	Polio
Diabetes	Epileptic seizures	Cancer
Tuberculosis	Asthma	Venereal Disease
Pneumonia	Alcoholism	AIDS / HIV
Stomach ulcers	Psoriasis	Other: ________________________
Previous heart attack	Previous stroke	

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 and cards are the property of RYCC and the replacement cost is $10. Missed appointments (no shows) without 24 hours notice are subject to a charge. Please be advised that an absence of 90 days without chiropractic care will require a re-examination at a fee of $50.

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

Royal York Chiropractic

Payment Office Policy Sheet

Please be advised that our office policy regarding payments for chiropractic care and related products is as follows:

1. The monthly payment option requires that you make a regular payment for chiropractic care on the 1st or the 15th of the month. Also note that the monthly payment option is by way of autobilling your credit card which you must leave on file at the office or provide us with post dated cheques which also remain on file at the office. In the event that you do not attend your chiropractic care for a specified month, as you are on a regular payment plan, you are still required to make the regular payment **without exception**.

2. Patients that wish to make a one time payment for chiropractic care (one time option) may pay by VISA, Mastercard, AMEX, Debit Card, Cheque or Cash.

3. Patients that wish to pay per visit for chiropractic care are **required to pay when the service is rendered or they may clear their account at the end of the week.** Overdue accounts will be subject to a concurrent 2.5% monthly service charge.

4. In event that you drop out of care prematurely, the full amount outstanding on your account will become due. This will immediately be billed to the credit card we have on file. A service charge of 2.5% of the original credit card charge will appear on your account. In the event that you have a credit on file, please notify us and we will gladly refund it by way of cheque.

5. Motor Vehicle Accident and WSIB patients are reminded that, in the event their insurance company does not pay for their chiropractic care, they are responsible for the entire balance outstanding.

6. Missed appointments (no-shows) are billed for the full service unless they are made up during the same week. Adjustments are $40.00 and examinations are $50.00. If you are on a plan, this amount will be deducted from your plan, thus affecting your year end date. If you would like to sign out and keep your x-rays for any reason, there is a $40.00 charge. Replacement charge for lost key-fobs and cards is $10.00. An absence of 90 days without chiropractic care will require a re-examination at a fee of $50.

7. We will provide monthly receipts reflecting services rendered to you to file with your insurance company for reimbursement. We will also provide receipts for income tax purposes on an annual basis when requested.

I hereby fully agree to and will abide by the Royal York Chiropractic Payment Office Policy.

Name in Full ____

Signature ______________________________ Date ___________

Sept 2013 update