

## Royal York Chiropractic

Dr. Peter J. Hryciuk, B.Sc. D.C. and Dr. Marco Capizzano, B.Sc. D.C.  
4237 Dundas St. W. Toronto Ontario M8X 1Y3 416.233.5413

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 will be performed to determine the cause(s) of your health problems.
- 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 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 message 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  Sex: male  female

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.**

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Patient Name: \_\_\_\_\_

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"/> Yes      |
| <input type="checkbox"/> Vacuum Extraction | <input type="checkbox"/> Pulling / Twisting by the Delivery Doctor |   | <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: _____<br>date(s)  |
| <input type="checkbox"/> Car Accident _____ Injuries: _____<br>date(s) | <input type="checkbox"/> Physical Fight _____ Injuries: _____<br>date(s) |
| <input type="checkbox"/> Car Accident _____ Injuries: _____<br>date(s) | <input type="checkbox"/> Other _____ Injuries: _____<br>date(s)          |
| <input type="checkbox"/> Other _____ Injuries: _____<br>date(s)        |  |

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

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

**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.

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Patient Name: \_\_\_\_\_

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.

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.

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Patient Name: \_\_\_\_\_

11. Have you experienced any traveling or referred pain into your arms, hands, legs or feet?

Yes

No

If yes, pain travels from \_\_\_\_\_ to \_\_\_\_\_  
(please indicate side of body)

12. 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 you **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.**

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Patient Name: \_\_\_\_\_

## 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 may 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

Backache  
Neck pain  
Foot trouble  
Shoulder pain  
Hernia  
Spinal curvature  
Poor posture  
Arthritis

#### GENERAL SYMPTOMS

Fever / Chills / Sweats  
Fainting  
Convulsions  
Allergy  
Skin problems  
Colds  
Tremors  
Loss of balance

#### GASTROINTESTINAL

Difficult digestion  
Belching or gas  
Nausea or vomiting  
Stomach pain / heartburn  
Constipation  
Colon trouble  
Liver trouble  
Gall Bladder trouble  
Diarrhea  
Bloody stools

#### STRESS SYMPTOMS

Headache / Migraine  
Dizziness  
Numbness / pins & needles  
Ringing in ears  
Loss of sleep  
Poor concentration  
Irritable / Nervousness  
Depression  
Decreased energy / fatigue  
Tension

#### RESPIRATORY

Chronic cough  
Spitting up phlegm / blood  
Chest pain  
Difficulty breathing

#### CARDIOVASCULAR

Rapid heart beat  
Slow heart beat  
High blood pressure  
Low blood pressure  
Chest pain  
Swelling of ankles  
Poor circulation

#### URINARY

Painful urination  
Waking up at night - urinate  
Blood in urine  
Increased urination

#### FEMALE ISSUES

Painful menstruation  
Excessive flow  
Irregular menstruation  
Cramps or backache  
Abnormal discharge

Post menopause  
Birth Control Pill  
Miscarriages

Date of last menstrual period:  
\_\_\_\_\_

#### E.E.N.T.

Deafness  
Earache  
Asthma  
Tonsillitis  
Sinus trouble

### 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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Patient Name: \_\_\_\_\_

### Payment Office Policy Sheet

Please be advised of our office policy regarding payments for chiropractic care and related products:

1. 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.
2. Patients that wish to make a one time payment for chiropractic care (one time option) may pay by VISA, Mastercard, American Express, Debit Card or Cheque.
3. The monthly payment option requires that you make a regular payment for chiropractic care on the 1<sup>st</sup> or the 15<sup>th</sup> 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, and you have an outstanding balance, you are still required to make the regular payment **without exception.**
4. In the 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. If you paid using credit card or debit card, a service charge of 2.5% of the original charge will appear on your account, together with missed appointment charges. In the event that you have a credit on file, please notify us and we will gladly refund it by way of cheque.
5. As of December 1<sup>st</sup>, 2014, and according to the Superintendent's Guideline no. 04/14, all motor vehicle accident patients who wish to file claims must prepay for their chiropractic care in advance. Patients will be reimbursed via their extended health insurance and/or motor vehicle company insurance(s).

The guidelines are as follows:

- Completion of all OCF documents according to claims.
- Payment in full according to financials allotted.
- After an adjustment is rendered, patient must sign off on all chiropractic statements.
- Royal York Chiropractic will fax invoices directly to insurer.
- Patient must mail chiropractic invoices directly to insurer.

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 is \$10.00. Fees for copying full patient file are a \$100 minimum charge.
7. We will provide monthly receipts reflecting services rendered for 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 \_\_\_\_\_

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Patient Name: \_\_\_\_\_

**Informed Consent to Chiropractic Treatment**

There are risks and possible risks associated 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 very 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 both 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 the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or 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.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I hereby consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

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

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Name: \_\_\_\_\_  
(please print)

\_\_\_\_\_  
Patient Signature (Legal Guardian)

Witness: \_\_\_\_\_