Royal York Chiropractic

Dr. Peter J. Hryciuk, 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 ? _____ 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.

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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:

- ☐ 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 **your mother** 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:**

_____

_____

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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: _____

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.

☐ 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 _____

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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 **<u>most important to you</u>** 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

STRESS SYMPTOMS

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

URINARY

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

GENERAL SYMPTOMS

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

RESPIRATORY

Chronic cough
Spitting up phlegm / blood
Chest pain
Difficulty breathing

FEMALE ISSUES

Painful menstruation
Excessive flow
Irregular menstruation
Cramps or backache
Abnormal discharge
Post menopause
Birth Control Pill
Miscarriages

Date of last menstrual period:

_____

GASTROINTESTINAL

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

CARDIOVASCULAR

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

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 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, 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 1st, 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: _____