

GLENWOOD CHIROPRACTIC & WELLNESS CLINIC

NAME: _____	DATE OF BIRTH: _____
ADDRESS: _____	CITY: _____
POSTAL CODE: _____	PHONE #: (h) _____
	(w) _____
E-mail address: _____	(c) _____
	Cell provider: _____
Medical Doctor: _____	Health Care #: _____
How did you hear of our clinic?	<input type="checkbox"/> from my medical doctor
	<input type="checkbox"/> from another patient: _____ (name)
	yellow pages: <input type="checkbox"/> book <input type="checkbox"/> online
	<input type="checkbox"/> walked/drove by
	<input type="checkbox"/> google (internet) search
	<input type="checkbox"/> newspaper ad <input type="checkbox"/> other : _____
Work / Private Health Insurance: _____	
Emergency Contact: _____	Phone Number: _____
Marital Status: <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> common-law <input type="checkbox"/> widow	# of kids: boys ____ girls ____

Would you prefer appointment reminders via: phone text email

Is the reason you came to this office related to a -

- | | | |
|-------------------------------|-----|----|
| A) Motor Vehicle Accident? | YES | NO |
| B) Work-related injury? (WCB) | YES | NO |

FEE SCHEDULE

<i>CHIROPRACTIC:</i>	Adult (18+)	Sen (60+)/Stu	Child (0-12)
Consultation	\$30	\$25	\$20
Initial Examination	\$30	\$25	\$20
Regular Visit	\$45	\$35	\$25
Active Release Technique	\$60	\$50	\$40
Laser Therapy	\$15		
Progress Exam	\$15		
X-Ray Review	\$25		
<hr/>			
<i>MASSAGE:</i>	30 minutes	\$45	
	60 minutes	\$80	
	90 minutes	\$100	
<hr/>			
<i>ACUPUNCTURE:</i>	Initial Exam	\$100	
	Treatment	\$75	
<hr/>			
<i>CUSTOM ORTHOTICS:</i>	\$400		

Unless prior arrangements have been made, all services must be paid for at the time they are provided.
WCB and motor vehicle accidents are directly billed to your insurance company.

CANCELLATION NOTICE – 12 hr. notice is required for ALL appointments.

I, the undersigned, have read the above statements and agree to them for the term of my care.

SIGNATURE: _____

DATE: _____

Informed Consent to Chiropractic:

GLENWOOD CHIROPRACTIC & WELLNESS CLINIC

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 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 medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate 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 consent to the chiropractic treatment recommended to me by the chiropractors of Glenwood Chiropractic & Wellness Clinic, including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care at Glenwood Chiropractic & Wellness Clinic.

Signature _____

Date _____

Informed Consent to Massage Therapy:

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension, or improvement of circulation. I understand that the therapist does not diagnose any illnesses or any other forms of disorder either mental or physical. I understand the therapist cannot prescribe any prescription drugs or conduct any specialized treatments including, but not limited to, spinal adjustments. I have stated all medical information that I am aware of and understand that failure to do so may adversely affect the outcome of treatment and hereby give my consent to have massage performed on me.

Signature _____

Date _____

Informed Consent to Acupuncture:

I am aware that methods of my treatment may include but are not limited to acupuncture, acupressure, Tui-Na (Chinese Massage), moxibustion, cupping, bleeding, gua sha, the manipulation of soft tissue and joints of the body, the use of electrical modalities, Chinese or Western herbal medicine, and nutritional counseling in order to improve my physical functions, internal ailments and to reduce or eliminate pain.

I have had the opportunity to discuss with the Acupuncturist the nature and purpose of acupuncture and Traditional Chinese Medicine. I understand that results are not guaranteed.

I understand that there are minor risks attendant to acupuncture treatment, including, but not limited to, slight bruising of the skin or bleeding. I understand that slight bruising is a common response to cupping and gua sha treatments. I will inform my Acupuncturist if I have any condition and/or taking any medication that interferes with blood clotting. I will notify my Acupuncturist if I have a pace maker or other surgical implants as electrical stimulation and the use of a heat lamp may be contraindicated. I will notify my Acupuncturist should I become pregnant or if I am trying to become pregnant as certain Traditional Chinese Medicine modalities may be contraindicated.

I do not expect the Acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure which the Acupuncturist feels, based on the facts know, is in my best interests.

I intend this consent to apply to all my present and future acupuncture care at Glenwood Chiropractic & Wellness Clinic.

Signature _____

Date _____

Confidential Case History

Patient Name: _____ Date: _____

Reasons for your visit: (list in order of priority)

(a) _____ (b) _____

(c) _____ (d) _____

How long have you had this problem? _____

When did your symptoms start? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
 Occasionally (26-50% of the day) Intermittently (0-25% of the day)

How are your symptoms changing?

- Getting better Not changing Getting worse

How bad are your symptoms at their: none unbearable
worst: 0 1 2 3 4 5 6 7 8 9 10
best: 0 1 2 3 4 5 6 7 8 9 10

What activities make your symptoms worse: _____

What activities make your symptoms better: _____

Do you sleep on your: Back Side Stomach

Who have you seen for your symptoms: No one Acupuncturist Physical Therapist
 Chiropractor Massage Therapist Medical Doctor

When and what treatment? _____

Have you tried home remedies? Yes No

If yes, please describe: _____

What tests have you had for your symptoms and when were they performed?

X-Rays date: _____ MRI date: _____ CT Scan date: _____ Other date: _____

List all prescription and over-the-counter medications and nutritional/herbal supplements you are taking:

List all surgical procedures you have had and times you have been hospitalized:

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

<input type="checkbox"/> Past	<input type="checkbox"/> Present		<input type="checkbox"/> Past	<input type="checkbox"/> Present		<input type="checkbox"/> Past	<input type="checkbox"/> Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Use Tobacco Products
						<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones			
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
					Weak Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Stress/Tension
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
					Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Earaches/Ringing
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Swelling						
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	Males Only		
<input type="checkbox"/>	<input type="checkbox"/>	Muscular In-coordination	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
Females Only								
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps			
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses			
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy Problems	<input type="checkbox"/>	<input type="checkbox"/>	Spotting			

List any other conditions you feel may be important: _____

Patient Signature: _____

DOCTOR'S NOTES:

DISABILITY QUESTIONNAIRE

(this allows us to determine how much your current health issues are affecting your daily life)

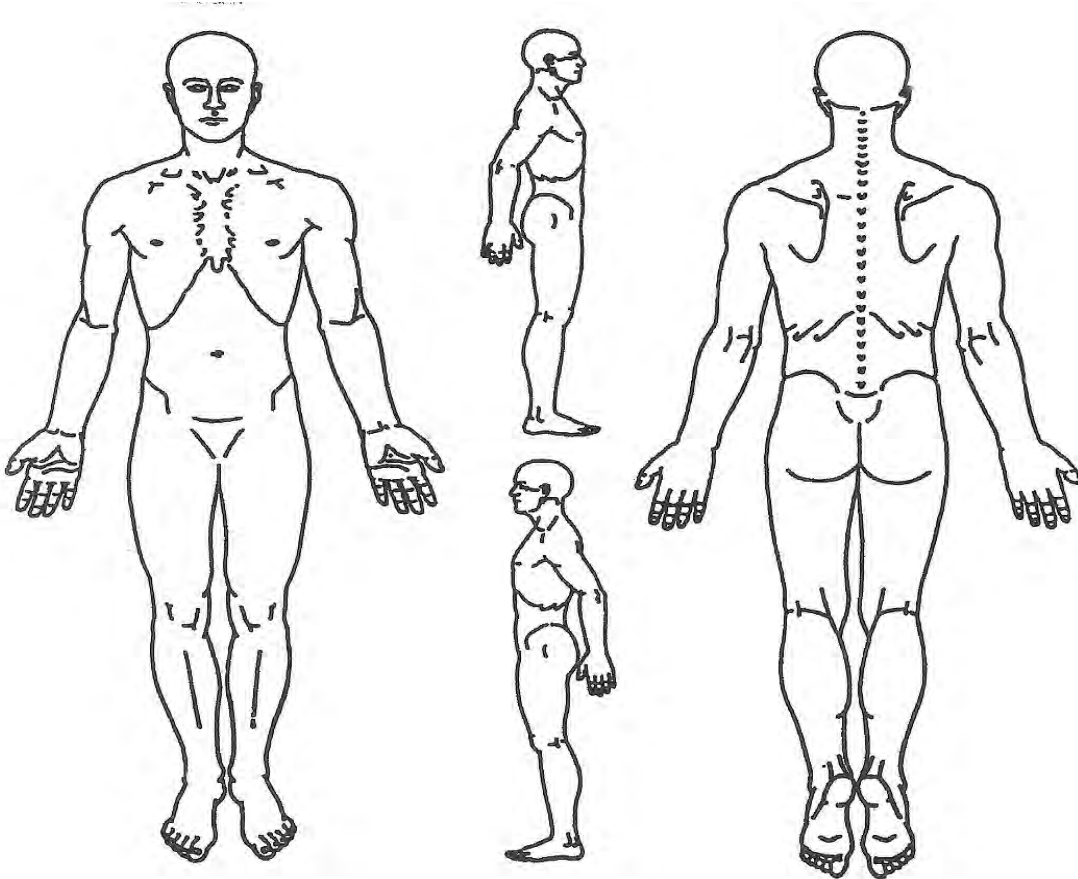
Name: _____ Date: _____

Age: _____ Occupation: _____ Employer: _____

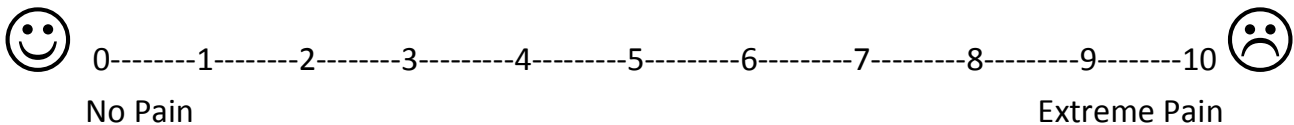
Full Time Part Time Seasonal Self Employed Student

SHOW US WHAT YOU ARE FEELING ON THE DRAWINGS USING THESE LETTERS

ACHE NUMBNESS PINS & NEEDLES BURNING STABBING
aa nn pp bb ss



If you are experiencing pain please circle the number which best describes your degree of pain:



TURN OVER PLEASE

Please circle the one choice which best describes how your problem affects you at this time -

SECTION 1 - Personal Care

My problems limit my ability to take care of personal needs such as washing, dressing, etc: Yes No
If yes, how much is it affected?

- A Slightly
- B Mildly
- C Moderately
- D Severely
- E Totally unable to care for myself.

SECTION 2 - Lifting

My ability to lift things is limited: Yes No
If yes, how much is it limited?

- A Slightly
- B Mildly
- C Moderately
- D Severely
- E Totally unable to lift.

SECTION 3 - Reading

My ability to read is limited: Yes No
If yes, how much is it limited:

- A Slightly
- B Mildly
- C Moderately
- D Severely
- E Totally unable to read

SECTION 4 - Concentration

My ability to concentrate is limited: Yes No
If yes, how much is limited?

- A Slightly
- B Mildly
- C Moderately
- D Severely
- E Totally unable to concentrate

SECTION 5 - Work

My ability to work is limited: Yes No
If yes, how much is it limited?

- A I can do most of my usual work.
- B I can work at about half of normal.
- C I can work at less than half of normal
- D I can hardly do any work.
- E Totally unable to work.

Comments: _____

Patient Signature: _____

Date: _____

SECTION 6 - Driving/Traveling

My driving comfort is affected: Yes No
If yes, how much is it affected?

- A Slightly
- B Mildly
- C Moderately
- D Severely
- E Totally, unable to drive.

SECTION 7 - Sleeping

My sleep is disturbed: Yes No
If yes, how much is it disturbed?

- A Less than 1 hour sleepless
- B 1-2 hours sleepless
- C 2-3 hours sleepless
- D 3-5 hours sleepless
- E Can hardly sleep at all.

SECTION 8 - Standing/Walking

My ability to stand/walk is limited: Yes No
If yes, how long can you stand/walk without trouble:

- A Several hours
- B More than 1 hour
- C No more than ½ hour
- D No more than 10 minutes
- E I must avoid standing/walking at all

SECTION 9 - Sitting

My ability to sit is limited: Yes No
If yes, how long can you sit without trouble?

- A A few hours
- B About 1 hour
- C About ½ hour
- D About 10 minutes
- E I must avoid sitting at all.

SECTION 10 - Social Life/Recreation

My social and leisure activities are limited? Yes No
If yes, how much is it limited?

- A Slightly
- B Mildly
- C Moderately
- D Severely
- E Totally unable to socialize.

PATIENT INSURANCE COVERAGE

If you or your spouse/partner have extended health insurance, please fill out this form prior to your next visit. All info can be obtained by phoning your insurance company.

Patient Name: _____ Birthdate: _____ Date: _____

Insurance Company _____

Insured's Name: _____ Birthdate: _____

Policy #: _____ Section #: _____

Plan #: _____ Group #: _____

ID #: _____ Contract #: _____

Will your insurance company send payment directly to the clinic? YES NO

Chiropractic - \$ _____ per year or \$ _____ per visit (\$ _____ 1st, \$ _____ after) or _____ %

Massage - \$ _____ per year or \$ _____ per visit (\$ _____ 1st, \$ _____ after) or _____ %

Do you need a prescription from your MD? YES NO

Acupuncture - \$ _____ per year or \$ _____ per visit or _____ %

Do you need a prescription from your MD? YES NO

Custom Orthotics - \$ _____ per year, every _____ years or _____ %

Do you need a prescription from your MD? YES NO

Health Spending Account - \$ _____ per year

Benefit Year: from _____ to _____

FOR OFFICE USE ONLY

Chiro: _____

Mass: _____

Acu: _____

Orth: _____