YONGE FINCH CHIROPRACTIC & HEALTH CENTRE

PATIENT APPLICATION FORM

Name: _____ (Age) _____ Gender: ☐ **M** ☐ **F**

Home Address: _____ _____ Home Phone: ( ) _____

City: _____ Province: _____, Postal Code: _____ Work Phone: ( ) _____EXT:

Email Address: _____ Cell Phone: ( ) _____

Birth Date (MM/DD/YY): _____ / _____ / _____ Marital Status: ☐ **S** ☐ **M** ☐ **D** ☐ **W**

Occupation: _____ Employer Name: _____

Emergency Contact Name: _____ Phone: ( ) _____

Family Physician Name: _____ Phone: ( ) _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No **If** so, when: _____

When did this condition begin? _____/_____/_____ **D**id it begin: ☐ Gradual ☐ Sudden ☐ Progressive over time?

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No **D**escribe: _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb ☐ Tingling ☐ Shooting

Does the Pain Radiate into your: ___ Arm ___ Leg ___ Does not radiate **Is** this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10% ☐ Only with Activity

Does complaint(s) interfere with: ____Work ____Sleep ____Hobbies ____ Daily Routine **Ex**plain: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Who have you seen for this? _____ **W**hat did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Have you had any imaging (X-rays, MRI or CT) done for your condition? ☐ Yes ☐ No When? _____

What were the findings of the imaging: ☐ Degeneration ☐ Slipped Disc ☐ Pinched Nerve ☐ Arthritis ☐ Bone Spur ☐ No Findings?

Did you know posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No

Explain: _____

TELL US ABOUT YOUR LIFESTYLE HABITS

Do you exercise? ☐ Yes ☐ No How often? **1X 2X 3X 4X 5X** per week **O**ther: _____

What activities? ☐ Running ☐ Jogging ☐ Weight ☐ Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming **O**ther: _____

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐Yes ☐ No How much / week? _____

Do you drink coffee? ☐ Yes ☐ No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

YONGE FINCH
CHIROPRACTIC
& HEALTH CENTRE

PATIENT CONSENT FORM

I do hereby authorize the doctors of **Yonge Finch Chiropractic and Health Centre** to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedures, including various modes of physical therapy and referral for diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes (1:5Mill), dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.
I understand the fee structure and accept full responsibility for prompt payment. Being late for the scheduled appointment may result in a shorter treatment. I understand that I am responsible for paying the full appointment fee if I do not give 24 hours notice of change or cancellation.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) of which I seek treatment.

Consent to evaluate and adjust a minor child

I, _____being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PATIENT SIGNATURE _____ **DATE** _____

DOCTOR SIGNATURE _____ **DATE** _____

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