Huron Church Family Wellness Centre
2780 Totten Street
Windsor, ON
N9B0A9
519-258-8544

Welcome!

Thank you for choosing our office. Attached are the forms we need to help us assess your overall health and wellness. Please carefully complete them and bring then to our staff at the front desk. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask.

Our goals are to first address the issues that brought you to this office and second to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical, and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of specific stresses, past and present that you face an allow us to better assess the challenges to your health potential.

I look forward to meeting you,

Reason for Consulting Our Office (please check)

__ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

__ After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.

__ After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.

__ I have a specific problem and require help only with this problem.

Personal Information

Name: _____

Address: _____City:_____ Postal Code: _____

Phone Number: _____ Cell: _____

Email Address: _____

Birth date _____

Referred By: _____

Do you have Extended Health Coverage? (ie. Green Shield) _____

Employer: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

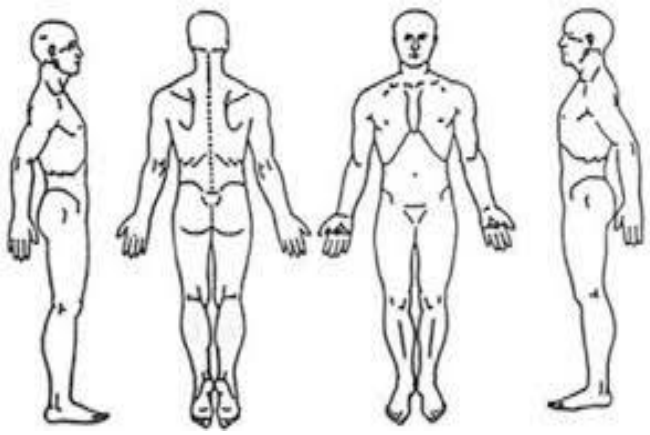
Health Concerns

What is your major concern at present? _____

_____

_____

Location of Pain(s) _____ (please indicate in diagram)



Intensity of pain: __ Mild __Moderate __Severe How long?_____

How is it in the Morning? _____ Afternoon? _____ Evening? _____

Does the Pain Wake you at Night? __ Yes __No Does it prevent sleep? __Yes __No

Does the Pain Travel Along the __Arms __Legs __Body Explain _____

Have you had this Pain Before? __ Yes __No When? _____ How long? _____

Did or Is another doctor treating this? __Yes __No if so, Name of Dr. And specialty_____
_____

What Makes the Pain Better? _____ What makes it Worse?_____

Has this area been X-rayed? __Yes __No If so, When? _____

Are you taking Pain Medication? _____ If so, When?_____ What? _____

Are you unable to Work due to the Pain? __Yes __No

Is there a Family History of this Problem? __ Yes __No With Whom? _____

Please List all Hospitalizations for Surgery, Broken Bones or Serous Illnesses(use back of page for additional information)

Date: _____ Reason _____

Date: _____ Reason _____

Other Medication Taken Currently or for any Past Long Term Condition:_____
_____

_____

Do any illnesses urn in your family? ie) arthritis, heart disease, highblood pressure etc Who? _____

General Health Profile

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

_ Neck Pain	__Pins and Needles	__Low Back Pain	__Allergies
__Headaches	__Numbness in fingers	__Pins and needles in legs	__Loss of Smell
__Lights bother eyes	__Shoulder Pain	__Numbness in toes	__Loss of Taste
__Dizziness	__Mid Back Pain	__Loss of balance	__Sinus Trouble
__Fainting	__Chest Pain	__Urinary Problems	__Fever
__Loss of Concentration	__Heartburn	__Foot Trouble	__Cold Sweats
__Buzzing in Ears	__Difficultly Breathing	__Stomach Upset	__Hot Flashes
__Earache	__Sleeping problems	__Constipation	__Depression
__Nervousness	__Cold Hand	__Diarrhea	__Irritability
__Tension	__Cold Feet	__Ulcers	__Mood Swings
__Fatigue			

Women Only: __Menstrual Pain __PMS Are you pregnant? _____

I hereby verify that to the best of my knowledge the proceeding and above information is accurate

Patient Name: _____

Signature: _____

Date: _____

Thank you for filling out this form. You have just completed the first step towards achieving you health goals!

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

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. 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 an lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are cause 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 examination and 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_____.

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

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TEL: (519) 258-8544

1. **Extended Medical Plans:**

Chiropractic services are covered by most extended health plans. Please provide the receptionist with any and all extended health coverage you may have.

We direct bill Green Shield and Great West Life only.

2. **Work Related Injuries (WSIB)**

Please inform the receptionist if you have been injured in the workplace. Chiropractic services are fully covered by WSIB (provided the claim is accepted)

3. **Motor Vehicle Accidents (MVA)**

Please inform the receptionist if you injuries are from a motor vehicle accident. Your insurance company will make full payments for treatments relating to a motor vehicle accident (provided the treatment plan is approved.

If you do not have any extended health coverage and your injuries are not work related or from an MVA you will be informed of an charges during your first visit. Payment is due and payable on the day service is rendered.

For you convenience we accept Visa, MasterCard, Debit, Cash and cheques.

I, _____ fully understand that if for any reason my appointment is not covered(by extended health, WSIB or MVA) I am responsible for paying the full amount.

Patient Name _____ Date _____

Patient Signature _____