Vitality Chiropractic Health Centre

Dr. Percy Chan

Chiropractor

2023 Sheppard Avenue East
Toronto, ON M2J 1W6
(416) 332-3769 • Fax (416) 335-1946

Welcome! This is what you can expect in your upcoming visits.

PAPERWORK

Please complete this simple admitting paperwork so we have an understanding of your past and current health situation.

CONSULTATION

After viewing an introductory chiropractic video, you will meet the doctor and discuss your health concerns.

EXAMINATION

We will conduct a thorough examination to locate the cause of your problem and determine if you are a candidate for chiropractic care. This includes a computerized assessment of how well your nervous system is communicating with your body. The assessment will include surface electromyography, which evaluates muscle function and balance, and dermothermography, which indicates any nerve irritation. The doctor may also need additional procedures, such as x-rays and a computerized gait analysis. If yours is a chiropractic case, we will develop a plan to help you.

REPORT OF FINDINGS

Your second visit will begin with a video that will answer many of your questions. After that, we will explain the results of your examination. If we think that we can help you, we will recommend a schedule of care created just for you. During this time we will also explain our financial policies and determine your insurance coverage, if applicable.

HEALTH TALK

We find that when patients are empowered to help themselves, they respond faster to care and remain healthier longer. This is why we offer you and those you care about an opportunity to attend our one-time evening session, where you will learn how to optimize your health.

Please complete the following pages to save time and help us to serve you better.

Thank you.

PERSONAL HISTORY

NAME (LAST, FIRST)		BIRTHDATE (DD/MM/YY)	SEX ❒ MALE ❒ FEMALE
ADDRESS	APT #	CITY	PROVINCE
POSTAL CODE	E-MAIL ADDRESS @	HOME PHONE	WORK PHONE
FAMILY DOCTOR	PHONE NUMBER	EXTENDED HEALTH COVERAGE (PROVIDER/ GROUP #/ POLICY #)	
BUSINESS/EMPLOYER		OCCUPATION	
STATUS ❒ MARRIED ❒ SINGLE ❒ WIDOWED ❒ DIVORCED ❒ SEPARATED ❒ COMMON-LAW			NUMBER OF CHILDREN/AGES
NAME OF EMERGENCY CONTACT	RELATIONSHIP TO YOU		PH. OF EMERGENCY CONTACT

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

CURRENT HEALTH CONDITION

CURRENT COMPLAINT(S)

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
❒ YES ❒ NO IF YES, DOCTOR'S NAME:

TYPE OF TREATMENT	RESULTS

HOW LONG HAVE YOU HAD THIS CONDITION?	HAVE YOU HAD THIS CONDITION BEFORE? ❒ YES ❒ NO	HEIGHT	WEIGHT	FOOT SIZE

IS THIS CONDITION RELATED TO YOUR:
❒ JOB ❒ FALL ❒ HOME INJURY ❒ AUTO ACCIDENT ❒ OTHER:

DATE/TIME OF ACCIDENT

WHAT MAKES YOUR CONDITION WORSE?
❒ SNEEZING ❒ COUGHING ❒ DEFACATION ❒ SITTING ❒ WALKING ❒ STAIRS ❒ BENDING
❒ STANDING ❒ LIFTING ❒ OTHER:

WHAT MAKES YOUR CONDITION FEEL BETTER?
❒ BED REST ❒ ICE ❒ HEAT ❒ MASSAGE ❒ MEDICATION ❒ OTHER:

YOUR CURRENT COMPLAINT GETTING:
❒ WORSE ❒ CONSTANT ❒ COMES AND GOES ❒ BETTER

CHARACTER OF PAIN:
❒ DULL ACHE ❒ SHARP ❒ FIERY ❒ TINGLING ❒ STABBING ❒ BURNING

IS THE PAIN:
❒ CONSTANT ❒ INTERMITTANT

PLEASE PLACE AN X ON THE GRADE BELOW, INDICATING THE SEVERITY OF YOUR PAIN.

0 No pain ——— 10 Most pain ever felt

PLEASE DESCRIBE HOW IT FEELS WHEN THIS PROBLEM IS AT ITS WORST.

COMPARE THIS PROBLEM AT ITS WORST AND A TIME WHEN YOU FEEL GREAT. HOW DOES THIS PROBLEM AT ITS WORST INTERFERE WITH:
YOUR ABILITY TO WORK:

YOUR ABILITY TO ENJOY YOUR FAMILY OR YOUR SOCIAL TIME:

YOUR ABILITY TO ENJOY YOUR HOBBIES OR SPORTS:

WHICH OF THE ABOVES DOES YOUR CONDITION MOST INTERFERE?

IF YOU DO NOT GET THIS PROBLEM CORRECTED, DO YOU THINK IT WILL GET WORSE OVER THE NEXT FIVE YEARS?
❒ YES ❒ NO

DRUGS YOU NOW TAKE:
❒ CHOLESTEROL ❒ PAINKILLERS/MUSCLE RELAXERS ❒ BLOOD PRESSURE MEDICINE ❒ INSULIN ❒ OTHER:

DO YOU SUFFER FROM ANY OTHER CONDITIONS?

IN WHAT POSITION DO YOU SLEEP?
❒ SIDE ❒ BACK ❒ STOMACH

AGE OF MATTRESS (YEARS):

HAVE YOU HAD X-RAYS TAKEN IN THE LAST SIX MONTHS?
❒ YES ❒ NO IF YES, WHERE:

WHAT WERE THE RESULTS?

DATE PATIENT NUMBER

PAST HEALTH HISTORY

MAJOR SURGERY/OPERATIONS

❒ HERNIA ❒ TONSILLECTOMY ❒ GALL BLADDER ❒ APPENDECTOMY ❒ BACK SURGERY ❒ BROKEN BONES
❒ HYSTERECTOMY ❒ C-SECTIONS ❒ OTHER:

CHILDHOOD TRAUMAS

SPORTS INJURIES

MOTOR VEHICLE ACCIDENTS

WORK INJURIES

HOSPITALIZATIONS (OTHER THAN ABOVE)

PREVIOUS CHIROPRACTIC CARE

❒ NONE ❒ DOCTOR'S NAME AND APPROXIMATE DATE OF LAST VISIT:

FAMILY HEALTH HISTORY

DOES ANY MEMBER OF YOUR FAMILY SUFFER FROM THE SAME CONDITION?

❒ NO ❒ YES ❒ WHOM:

HAVE YOUR CHILDREN EVER HAD A SPINAL CHECK-UP?

❒ NO ❒ YES ❒ IF YES, WHERE AND WHEN?

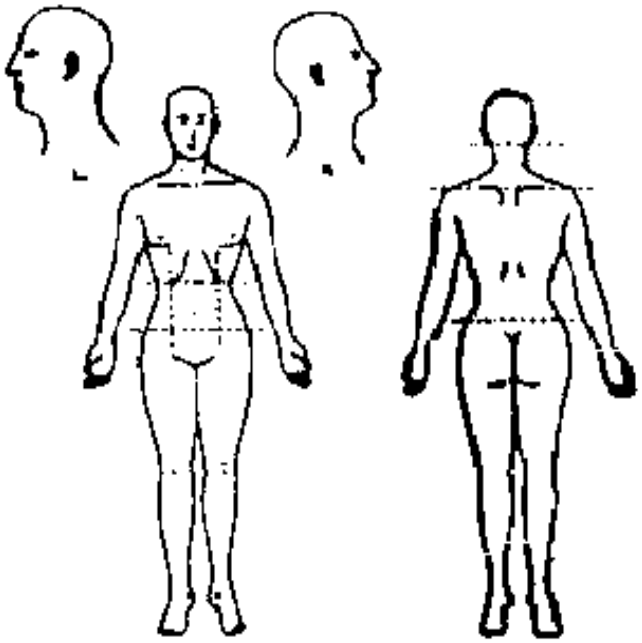
SIGNS AND SYMPTOMS

When there is no interference, your nervous system controls the healthy function of virtually every cell, organ and system in the body. Carefully read the list below and please check any conditions that you may have experienced in the last six months. While some of the conditions may seem unrelated to the purpose of your appointment, always remember that nervous system interference may express itself in many ways.

- ❑ HEADACHES
- ❑ MIGRAINE HEADACHES
- ❑ DIZZINESS
- ❑ FATIGUE
- ❑ HEAD COLDS
- ❑ VISION PROBLEMS
- ❑ HEARING PROBLEMS
- ❑ SINUS PROBLEMS
- ❑ COMMON COLD
- ❑ ALLERGIES
- ❑ RUNNY NOSE
- ❑ SORE THROAT
- ❑ TONSILLITIS
- ❑ HOARSENESS
- ❑ LARYNGITIS
- ❑ STIFF NECK
- ❑ COUGH
- ❑ CROUP
- ❑ PAIN IN THE UPPER ARM
- ❑ TENNIS ELBOW
- ❑ WRIST, HAND AND FINGER NUMBNESS
- ❑ WRIST, HAND AND FINGER PAIN
- ❑ SHORTNESS OF BREATH
- ❑ DIFFICULTY IN BREATHING
- ❑ ASTHMA
- ❑ HEART CONDITIONS
- ❑ CHEST PAINS
- ❑ BRONCHITIS
- ❑ PNEUMONIA, CONGESTION
- ❑ GALLBLADDER CONDITIONS
- ❑ HIATAL HERNIA
- ❑ BLOOD PRESSURE PROBLEMS
- ❑ LIVER CONDITIONS
- ❑ JAUNDICE
- ❑ SKIN CONDITIONS, ACNE OR PIMPLES
- ❑ STOMACH PROBLEMS
- ❑ INDIGESTION
- ❑ HEARTBURN
- ❑ GASTRITIS
- ❑ ULCERS
- ❑ BLOOD SUGAR PROBLEMS
- ❑ KIDNEY PROBLEMS
- ❑ GAS PAINS
- ❑ CHRONIC TIREDNESS
- ❑ IRRITABLE BOWEL
- ❑ CONSTIPATION OR DIARRHEA
- ❑ HERNIAS
- ❑ STERILITY
- ❑ BLADDER PROBLEMS
- ❑ MENSTRUAL PROBLEMS
- ❑ MENSTRUAL CRAMPS
- ❑ BED WETTING
- ❑ KNEE PAINS
- ❑ SCIATICA
- ❑ LOW BACK PAIN
- ❑ DIFFICULT OR PAINFUL URINATION
- ❑ NUMBNESS IN LEGS
- ❑ POOR CIRCULATION IN LEGS
- ❑ SHIN SPLINTS
- ❑ SWOLLEN ANKLES
- ❑ WEAK ARCHES
- ❑ LEG CRAMPS OR COLD FEET
- ❑ SACROILIAC PROBLEMS
- ❑ HEMORRHOIDS
- ❑ PAIN AT THE END OF THE SPINE

Please outline on the diagram the area of your discomfort and any radiation of pain using the appropriate symbol.

Numbness	Pins and needles	Burning	Ache	Stabbing
----	oooo	xxxx	****	////



WHY ARE YOU HERE TODAY?

People seek chiropractic care for a variety of reasons. Some are looking for **relief care**. Others are interested in **corrective care**. Still others want **preventative/maintenance care**. These are the three phases of care. Your doctor will consider your needs and desires when recommending your schedule of care. Remember that your prepared recommendation is an incorporation of all three phases of care. What is your goal of care?

- ❑ **Preventative/Maintenance care**
  I would like my body to function at its highest state possible.
- ❑ **Corrective care**
  I want to correct the cause of my problem corrected and relief from my symptoms.
- ❑ **Relief care**
  I only want to be relieved from my current symptoms.

What are you hoping to achieve on your first visit with us today?

PLEASE READ CAREFULLY

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that Chiropractic care is considered very safe with an extremely low risk rate by any standard. I further understand that there are, however, some risks (rib fractures and strokes) associated with chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I have read and understood the above, and I have had sufficient opportunity to discuss it's content with the Doctor of Chiropractic indicated below. I do hereby request and consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic indicated below, for my present condition and for any future conditions for which I may seek care. I also agree to payment for all services rendered.

Name (printed) _____ Date _____

Signature _____ D.C. _____ Initial _____