Merivale Chiropractic and Massage Clinic
460 West Hunt Club Road
at Merivale Rd.
Ottawa, ON K2E 0B8
613-226-8142

Patient Introduction

Personal History:

Mr.__ Mrs.__ Miss__ Ms.__ Dr.__

Name: _____
First Middle Last

Your Address: _____

City:_____Prov:_____ Postal Code:_____

Telephone: Home:_____ Bus:_____ Cell:_____

E-Mail: _____

☐ Check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

Birth Date: (DD-MM-YYYY) _____-_____-_____ Age:_____ Male:____ Female:____

Occupation: _____ Employer: _____

Marital Status:_____ Spouse's Name:_____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving: _____

_____

Present MD: _____ City: _____

Referred to our Centre by: _____

☐ Would you or your workplace/common interest group benefit from a complimentary workshop on how to improve health and reduce injuries?

MERIVALE CHIROPRACTIC CLINIC

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$150.00
Radiology	$0.00-$84.00 (subsidized by OHIP)
X-Ray Reading /Report	$30.00
Adjustment /Visit	$45.00
Modality / Traction	$20.00 (in addition to regular visit fee)
Year End Progress Exam	$40.00
Acupuncture with Adjustment	$25.00 (in addition to regular visit fee)
Acupuncture 15 minute	$50.00
30 minute	$60.00
45 minute	$80.00
1 hour	$100.00
Motor Vehicle Accident FSCO Submission Fee	$45.00 (one-time fee)

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, will be included in your initial fee.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

Who is responsible for your bill:

You:____ Spouse:___ Auto Ins.:___ WSIB:___ Extended Health Ins.:_____

SIGNATURE: _____ DATE: _____

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

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Adult Consultation History

Your Name: _____

Your Main Complaint: _____

Any other Complaints: _____

_____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

_____

What do you do that makes this problem worse? _____

_____

How much older does this make you feel: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___, Intermittent ___, Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

Are you on any type of medication?_____, Please list all: _____

_____

Could your problem have been caused by an injury at work?_____

If yes, please give us the details: _____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this?_____

_____

Do you have any children? _____# of children: _____

Children's Names:_____

Do they have any health problems that you are aware of? _____

_____

Is there any other information you would like us to know?_____

_____

_____

_____

SIGNATURE: _____ DATE: _____

For Women Only

Date of your last menstrual period: _____Do you suffer from PMS? _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Thank You!

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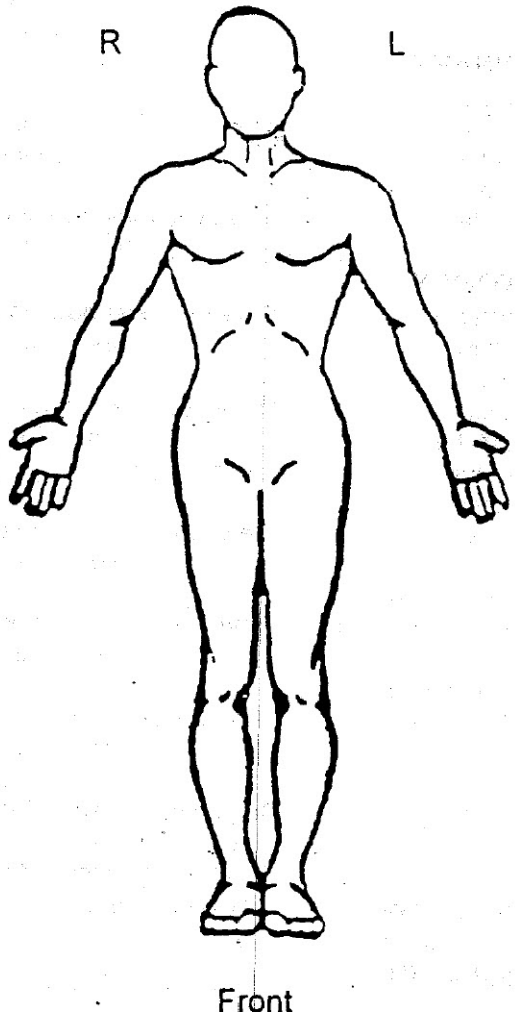
MCC Symptom Diagram

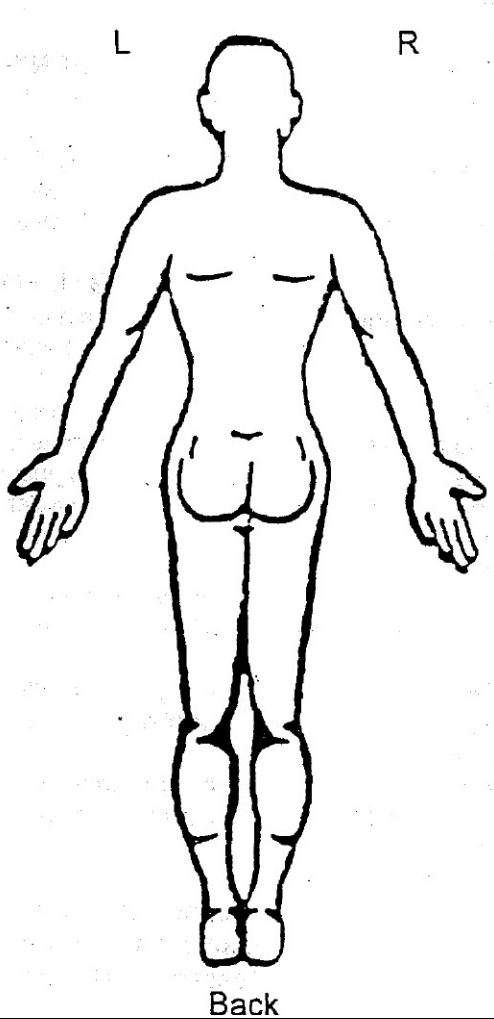
Patient Name: _____ **File #:** _____ **Date:** _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

Symbols:

Numbness	≡≡≡	Pins & Needles	⁘⁘
Burning	X X X X X X X X	Stabbing & Sharp	///
Dull & Aching	+ + + + + + + +	Stiff & Tight	2 2 2 2 2 2 2 2





Health Status Survey

Patient Name: _____ **File #:** _____ **Date:** _____

Please circle (**O**) any conditions or symptoms presently causing you problems.
Please check (√) those conditions or symptoms, which have been a problem to you in the past.

GENERAL SYMPTOMS
- ❑ Loss of consciousness
- ❑ Blackouts
- ❑ Headache
- ❑ Fever
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Clumsiness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Numbness or tingling
- ❑ Pain
- ❑ Nervousness
- ❑ Loss of weight

MUSCLES & JOINTS
- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Shoulder pain
- ❑ Arm/Forearm pain
- ❑ Elbow pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Arthritis
- ❑ Weakness or loss of strength

E.E.N.T.
- ❑ Blurred vision
- ❑ Failing vision (one/both eyes)
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Eye pain
- ❑ Deafness, Earache
- ❑ Ringing, buzzing, any noise in the ears
- ❑ Asthma
- ❑ Frequent colds
- ❑ Sinus infection
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Slurred or other speech problems
- ❑ Difficulty swallowing

RESPIRATORY
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficulty breathing

CARDIOVASCULAR
- ❑ Bleeding Disorder
- ❑ High blood pressure
- ❑ Pain over heart
- ❑ Stroke
- ❑ Hardening of arteries
- ❑ Varicose veins
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Heart or blood disease
- ❑ Angina

GENTOURINARY
- ❑ Trouble urinating
- ❑ Blood in urine
- ❑ Kidney infection
- ❑ Bed-wetting
- ❑ Prostate trouble

G.U. FOR WOMEN
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Vaginal, discharge
- ❑ Swollen breasts
- ❑ Lumps in breasts

Have you ever been on birth control pills? Yes ❑ No ❑

Are you currently taking the birth control pill? Yes ❑ No ❑

# of pregnancies _____
# of children _____

Please inform the doctor if you have ever been tested for HIV or Hepatitis A/B/C.

SKIN
- ❑ Rashes, itching
- ❑ Bruise easily
- ❑ Dryness
- ❑ Boils
- ❑ Hives (allergy)

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Indigestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting (blood?)
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Gall bladder trouble
- ❑ Intestinal worms
- ❑ Ulcer
- ❑ Diabetes

Have you ever had any fractures? Yes ❑ No ❑

Have you ever been in a car accident? Yes ❑ No ❑

Have you ever been hospitalized? Yes ❑ No ❑

If yes, why? _____

Are you currently a smoker? Yes ❑ No ❑

Have you ever smoked in the past? Yes ❑ No ❑

Have you ever been diagnosed with cancer? Yes ❑ No ❑

Do you take medication on a regular basis? Yes ❑ No ❑

If so, what? (blood thinner, blood pressure, etc.) _____

_____

Please complete the reverse side