DOUGLASDALE
FAMILY CHIROPRACTIC

Adult Introduction Form

Today's Date: _____

AHC#: _____

Last name: _____

First name: _____

Date of birth: _____ Current age: _____

Marital status: S M C-L D W Gender: Male Female

# of Children: _____ Their ages: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Home phone number: _____

Cell phone number: _____

Email address: _____

Would you like to receive our monthly wellness newsletter? Yes No

Occupation/Employer: _____

Emergency contact: _____

Emergency contact number: _____

Previous chiropractor: _____

Date of last visit: _____

Who may we thank for referring you? _____

Physical History: Please tell us what brought you into our office.

Wellness ***Maintenance*** ***Specific Symptom*** ***Auto Accident***

If you currently have specific symptoms, what is your major complaint?

_____

How long has it been since you really felt good? _____

What is the goal that you would like to achieve by having your optimum health restored? _____

_____

Please list any of the following injuries:

Auto: _____ Sports: _____

Work: _____ Other: _____

Chemical History: Please list any current medication, pain-killers and/or supplements: _____

_____

Emotional History: Please let us know about any recurring stress, loss or abuse in your life that you feel we may need to be made aware of? _____

_____

_____

Please check any of the following symptoms that you presently have or have experienced in the past:

Eyes, Ears, Nose & Throat:

Colds_____times per year
Ear ringing / aches / discharge
Nasal obstruction
Sinus infection
Enlarged glands
Difficulty swallowing
Tonsillitis
Eye pain
Double / burred / loss of vision

Neurological:

Allergies
Seizures
Dizziness
Abnormal loss of weight
Fainting / concussions
Tremors
Headaches / migraines
Loss of sleep
Nervousness / depression

Respiratory:

Chest pain
Chronic cough
Difficulty breathing
Wheezing
Spitting Blood
Asthma

Pain or Numbness In:

Left	Right	Shoulder
Left	Right	Arm
Left	Right	Elbow
Left	Right	Hands
Left	Right	Fingers
Left	Right	Hip
Left	Right	Knee
Left	Right	Foot
Left	Right	Toes

Low back pain
Neck pain/ stiffness
Tailbone pain
Pain between shoulders
Muscle cramping
Jaw problems

Gastrointestinal:

Constipation / diarrhea
Difficult digestion
Nausea
Stomach pain

Other Conditions:

Cancer
Herniated / degenerated disc(s)
Heart disease
High blood pressure

Genitourinary:

Diabetes
Abnormal urine / urination
Frequent urination (>20x/day)
Lack of control of urination
Kidney infection
Prostate troubles

Women Only:

Cramps
Irregular flow
Irregular / painful cycle
Abnormal discharge
Sore breasts
Menopause
Pregnant: due date: _____
Last menstruation: _____

Please list any other problems that you have or have been seeing your family doctor for:

_____

_____

Health and Wellness:

Are you interested in learning more about the other services offered in the office?

- Ideal Protein Weight Management System/Nutrition Coaching
- Footmaxx Custom Orthotics
- Chiroflow Waterbased Pillows
- Quality Vitamins & Supplements
- Massage Therapy
- Acupuncture

Your personal information will be held in the strictest confidentiality and is used only for the clinical purposes at Douglasdale Family Chiropractic. If you have any areas that you are not comfortable discussing or that require further confidentiality, please speak directly to the Doctor about them.

Douglasdale Family Chiropractic
Our Policies & Commitments

Welcome to our office! We thank you for choosing us.

Mission Statement

Our Mission is to inspire families to reach for a higher potential.

OUR COMMITMENTS TO YOU:

1. Reduce nerve interference.
2. Educate you and your family about health, healing, and well-being.
3. Create a program of care that meets your personal goals and timetable.
4. Run the office on time.
5. Book extra time upon request to answer any attentional questions you may have.
6. Be flexible whenever possible if appointments need to be changed.
7. Treat you like a member of our family. (as a member of our family, if you have any questions or concerns that can't be answered at the office, please call Dr. Darren at 403-671-7135 or Dr. Nolan at 587-225-1962).

YOUR COMMITMENTS TO US:

1. Keep your appointments, as each adjustment builds on the one before.
2. Give 24-hour notice for an appointment change, whenever possible. (We reserve the right to bill your account $25 if notice is not given).
3. Rebook an alternate appointment for the same week if you need to change an appointment.
4. Arrive on time for each of your scheduled appointments.

Fees:

Douglasdale Family Chiropractic operates on a **fee for service basis** and fees are due at time of care. Fees for chiropractic services are as follows:

Service	Price	Includes
Initial Adult Exam	$75	Covers consultation, examination, spinal scans, and report of findings with the chiropractor
Initial Infant / Child Exam	$80	Covers consultation, examination, and first adjustment
Regular Visit	$48	Adjustment
Senior Visit (65+)	$38	Adjustment
Re-Examination / Re-Entry Visit	$25	Patients who have not been in for over 6 months or have sustained a new injury / accident
Re-Scan	$25	A chiropractic exam and spinal scans to establish patient progress
After Hours Emergency	$75	
Custom Orthotics	$415+	Orthotic scan, and report of findings included.

Extended Health Benefits: Receipts will be provided for you to send to your insurance company. Receipts may also be issued for tax purposes.

We direct bill for Motor Vehicle Accidents within the first 90 days post-accident and following this will provide receipts for the remainder of the MVA protocol.

Please Note: We are **not a WCB authorized chiropractic provider

Contact information – To serve you better, our office does email appointment reminders and bookings.

Would you like to use email reminder services? Yes No

I have read all the above office policies and understand and accept my responsibilities as a practice member.

Signature:_____ Date: _____

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

BENEFITS

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

RISKS

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

ALTERNATIVES

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

QUESTIONS OR CONCERNS

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____	_____	_____
Name (Please Print)	Signature of patient (or legal guardian)	Date
_____	_____	_____
Name of Chiropractor	Signature of Chiropractor	Date