Health Centre of Milton

420 Main St. E. Unit 102 &103 Milton, Ontario, L9T 1P9
P: 905-878-8131 F: 905-878-9167

NEW PATIENT

Mr./Mrs./Miss./Ms: _____ First Name: __________________________ Surname: ___________________

Birth Date: (day/month/year)__________/___________/_____________ Age: _____________________

Address: M/F:

City/Town: Postal Code:

Phone Number: (home) (Cell) (Work)

May we leave a message when calling you? Yes ☐ No ☐

E-mail (Correspondence and Newsletters):

☐ Please check this box if you DO NOT want to receive e-mails for newsletters and events.

Occupation:

Employed by:

Who referred you to our clinic? Or how did you hear of us: ____

Height: Weight: Number of Children:

Have you had Orthotics Previously?

Family M.D. Phone Number:

Is your injury due to: Motor Vehicle Accident ☐ Work Place Injury ☐

I understand that any insurance coverage besides WSIB and MVA is an arrangement between the insurance company and myself. I give consent for the HCM staff to release treatment dates to my insurance company. I understand and agree that all services rendered are charged directly to me and that I am responsible for payment. I consent to sharing my personal health information with any treating practitioners/HCM staff involved in my care. Please note that all information provided will be kept confidential unless allowed or requested by law. Your written permission will be required to release any information.
I understand that 24 hours is needed to cancel an appointment or full fee will apply.

DATE: _____________________ SIGNATURE: ______________________________

For RCMP Officers ONLY

Health Plan Card I.D: **Unit:** **Division:** **Collator:** .

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Please circle **(O)** any **current** conditions or symptoms. **Name:**______________________
Please check **(√)** beside **past** conditions or symptoms. **Date:**________________________

General Symptoms
Loss of consciousness
Blackouts
Headaches/Migraines
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions/Tremors
Loss of sleep
Loss of weight
Depression
Fatigue
Nervousness
Numbness/Pain or Tingling

Muscle & Joint
Arthritis
Weakness/Loss of strength
Swollen joints
Back pain
Shoulder pain
Arm/forearm pain
Elbow pain
Wrist pain
Hand pain
Knee/leg pain
Painful tailbone
Foot trouble
Stiff Neck
Sciatica
Scoliosis

Skin
Sensitive skin/loss of sensation
Rashes/eruptions/itching
Acne
Cold sores
Infectious skin condition
Bruise easily
Hives
Eczema/psoriasis
Boils

Gastrointestinal
Blood in stool
Vomit
Colitis/Crohn's
Constipation
Diarrhea
Difficult digestion/indigestion
Poor appetite/excessive hunger
Belching or Gas
Vomit (blood?)
Food allergies:_____________
Gall bladder troubles
Heart burn
Jaundice/Liver trouble
Nausea
Pain over stomach
Intestinal worms
Ulcers

Eyes/Ear/Nose/Throat
Blurred vision
Double vision
Eye pain
Deafness
Ear issues:________
Frequent colds
Enlarged glands
Enlarged thyroid
Nose bleeds
Sinus infection
Difficulty swallowing
Speech problems

Respiratory
Asthma
Anaphylaxis
Chest pain
Chronic cough
Bronchitis
Spitting up blood
Spitting up phlegm
Wheezing
Shortness of breath
Emphysema
Infectious respiratory condition
Family History

Cardiovascular
Pain over heart
Poor circulation
Swelling of extremities
High/Low blood pressure
Hardening of arteries
Varicose veins
Heart or blood disease: _______
Presence of pacemaker
Heart attack/stroke
Family History

Other Conditions
Epilepsy
Herpes
Hepatitis
Plantar warts
TB
HIV, AIDs
Diabetes: ☐Type 1 ☐Type 2
Gout
Fibromyalgia
Multiple Sclerosis
Parkinson's
Hemophilia
Osteoporosis
Other: _____________

Women Only
Breast tenderness/swollen breasts
Cramps or backache
Excessive flow
Irregular cycles
Menopausal (hot flashes, mood swings)
Painful menstruation
Pregnant-Due Date:_____________
# of children _____
Hysterectomy

Gentourinary
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

Updated:____________________

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Name:_________________________________ **Date:**___________________________

Please indicate if you have/had/been any of the following:

Falls/fractures/dislocations date: __________________
Pins/plates/rods date: __________________
Surgery date: __________________
Accidents date: __________________
Hospitalized date: __________________
Knocked unconscious date: __________________

How is your general health? ____

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) ______________________________

Area of Major Complaint:____

In the diagram 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.

Symbols:

Numbness	≡≡≡	Pins & Needles	::::
Burning	xxxx xxxx	Stabbing & Sharp	////
Dull & Aching	++++ ++++	Stiff & Tight	2222 2222

R L L R

Front Back

Updated:____________________

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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.

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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 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 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)

__________________________________ Date:________________20_____
Signature of patient (or legal guardian)

__________________________________ Date:________________20_____
Signature of Chiropractor

____
Name of Chiropractor (Please Print)

Furthermore, the successful doctor-patient relationship is based on a commitment by both parties participating in the process of recovery. I understand that my healing response to the care provided in this clinic involves my full and honest participation. I acknowledge that I am committed to facilitate any lifestyle modifications that are in my best interest. I am aware that if I choose not to comply with the treatment and follow-up recommendations, I may adversely affect my health and not realize all of the possible benefits from care.

I have read the above consent information. I have also had an opportunity to ask questions about its content and by signing above, I agree to the above named procedures and guidelines. I commit myself to fully participating with my own care and recovery by developing a deeper understanding of how to best help myself, and will utilize the tools provided for me that can assist me in the recovery and healing process.