

# BROADMEAD BETTERBACK

250-744-2882

<b>Patient Registration Form</b>	<b>Today's Date:</b>
----------------------------------	----------------------

<b>Last Name</b>	<b>Initial</b>	<b>First Name</b>	<b>Home #</b>
<b>Address</b>			<b>Work #</b>
<b>City / Postal Code</b>			<b>Cell #</b>
<b>Male</b>	<b>Female</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>Email</b>
<b>Name of spouse or significant other</b>			<b>Employer</b>
<b>Number of children</b>			<b>Occupation</b>

<b>Personal Health Number (BC Care Card)</b>	<b>Do you have private insurance for chiropractic? Y/N</b>
<b>Family Doctor</b>	<b>If so, how much is your annual benefit?</b>
<b>How did you hear about our office?</b>	A. Someone referred me      B. Phone Book      C. Website/Internet D. Another doctor suggested it      E. Other: _____

<b>Purpose of this Visit</b>
Why are you here today?
Is today's visit the result of:    a CAR ACCIDENT?    or,    a WORK INJURY?
When did your current problem start?
Has it gotten      BETTER      WORSE      STAYED THE SAME
Have you experienced this before?
If yes, how long has this been bothering you?
How often does this bother you?
What makes it better?
What makes it worse?

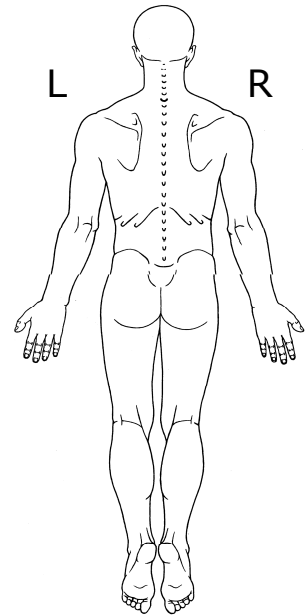
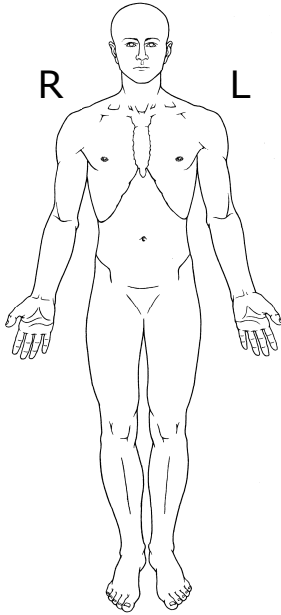
Height:
Weight:
Wt. changed 10 lbs or more in last year? <b>Y / N</b>
<b>Please list any <u>medications</u> you take or <u>surgeries</u> you have had</b>
<b>Please list any dietary supplements you take</b> e.g. vitamins and minerals

<b>Please briefly describe any accidents or other injuries you have had</b>

<b>Please briefly describe your exercise habits</b>

Please draw the location of your symptoms on the body outline below, using the appropriate symbol(s).

Ache AAA	Burning BBB	Numbness NNN	Pins and Needles +++	Stabbing ///	Stiff and Tight 222	Shooting Pain → → →
-------------	----------------	-----------------	-------------------------	-----------------	------------------------	------------------------



**Abnormal postural habits** are the result of trauma or stress to the body that have misaligned the vertebrae of your spine, which causes stress to the spinal cord and delicate nerves that pass between the vertebrae. These misalignments are called **SUBLUXATIONS** (sub-lux-a-shuns). The most common and detrimental postural distortion is HEAD FORWARD POSTURE, which weakens and affects the entire spine.

Please CHECK anything that applies to you now, or CIRCLE anything that applied in the past.

**GENERAL:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Unexplained weight change | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Compression Fracture       | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Disc or Joint Degeneration | <input type="checkbox"/> Whiplash             |

**NECK:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck pain   | <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Jaw problems          |
| <input type="checkbox"/> Stiff neck and shoulders                              | <input type="checkbox"/> Dizziness or balance problems | <input type="checkbox"/> Sinus problems        |
| <input type="checkbox"/> Numbness or tingling in:<br>Shoulders, arms, or hands | <input type="checkbox"/> Visual problems               | <input type="checkbox"/> Low energy or fatigue |
|  | <input type="checkbox"/> Weakness in grip              | <input type="checkbox"/> Thyroid problems      |

**MID-BACK:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mid-back pain    | <input type="checkbox"/> Rib problems                      | <input type="checkbox"/> Lung problems                  |
| <input type="checkbox"/> Heart problems   | <input type="checkbox"/> Difficulty or pain with breathing | <input type="checkbox"/> Recurrent lung infections      |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Indigestion or heartburn          | <input type="checkbox"/> Asthma, allergies, or wheezing |

**LOW-BACK:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Low-back pain                                   | <input type="checkbox"/> Sciatica                      | <input type="checkbox"/> Painful or irregular menstrual cycle |
| <input type="checkbox"/> Stiff low-back                                  | <input type="checkbox"/> Muscle cramps in legs or feet | <input type="checkbox"/> Sexual dysfunction                   |
| <input type="checkbox"/> Numbness or tingling in:<br>Butt, legs, or feet | <input type="checkbox"/> Weakness in back or legs      | <input type="checkbox"/> Frequent or difficult urination      |
|  | <input type="checkbox"/> Constipation or diarrhea      |   |

**Have any of your blood relatives had any diseases or significant health concerns? If so, please describe below. (M=Mother F=Father B= Brother S=Sister G=Grandparents)**

# Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic, medical doctors, and physiotherapists. 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 techniques;
- 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; rather, recent studies indicate 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 and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by 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 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 intend this consent to apply to all my present and future chiropractic care.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Signature (or Legal Guardian)

\_\_\_\_\_  
Witness of Signature

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please print)

# Office Policies

1. **All fees are due prior to services being rendered. Most patients enjoy the convenient option of pre-paying for their program.** You are welcome to pay-as-you-go. However, payment is still due prior to services being rendered. We accept Cash, Debit, VISA, MasterCard, and Personal Cheques.
2. If you choose to discontinue your care for any reason, you are responsible for the services you have received, at our regular fees. Refunds for any prepaid services will be issued within three business days. Our Fees for Services are as follows:

New Patient Examination	\$75
Adjustment	\$44
Spinal Decompression Therapy	\$44

3. Many insurance companies have benefits covering all or part of your care. Please check your individual health plan for details. We will gladly provide all necessary receipts to facilitate your claim. You will be responsible for the difference between our regular fees and the amount covered by your plan.

**I have read the above policies and accept responsibility for my payment.**

<p>Print Name of Patient or Legal Guardian</p> <hr/>
<p>Signature of Patient or Legal Guardian</p> <hr/>

**THANK YOU and WELCOME**