

PATIENT ENTRANCE FORM

Personal Information

Date: _____

Name: _____ Birth Date (D/M/Y): _____ Age: _____ Sex (M/F): _____

Address: _____ City: _____ Prov: _____

Postal Code: _____ Home #: _____ Work #: _____ Cell #: _____

Email: _____ Marital Status: M / W / D / S

Occupation: _____ Employer: _____

Insurance company: _____ Policy #: _____

Emergency contact: _____ Relationship: _____ Contact #: _____

How did you hear about our office?

Referred: Dental patient: Newspaper: Sign:

If referred, who may we thank for referring you : _____

Current Health Condition

Purpose of this appointment: _____

Other health professionals seen: _____

Name of other professionals: _____

Type of treatment: _____

Results: _____

Any medications for this condition: _____

Xrays taken: Yes No Date: _____ Results: _____

When did the condition begin: _____

Has this condition occurred before: Yes No If so, when: _____

Medical information

Previous chiropractic care: Yes No If yes, chiropractor's name: _____

Chiropractor's address: _____ Chiropractor's phone #: _____

Previous Chiropractic techniques used: _____

Family medical doctor: _____ MD's phone #: _____

Last checkup date: _____ Last physical date: _____

Current medications: _____

Past medications: _____

PAIN SCALE

Patient name: _____ Date: _____

Mark the areas on your body where you feel your pain. Include all affected areas. If the pain radiates, draw an arrow from where it begins to where it ends. Use the appropriate symbol(s) below.

Ache >>>>>

Burning X X X X

Tightness # # # #

Numbness = = = =

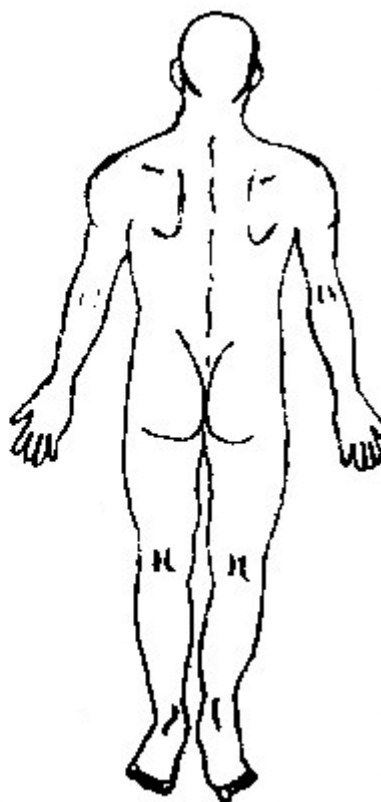
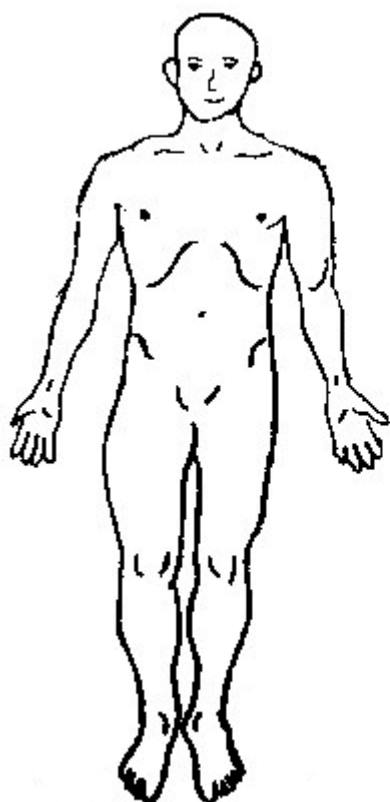
Stabbing * * * * *

Scars + + + + +

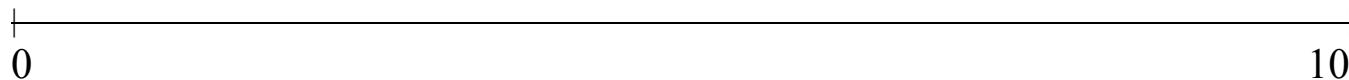
Pins & Needles O O O O

Throbbing ~ ~ ~ ~ ~

Past broken bones ? ? ? ? ?



On a scale of 0 to 10, please mark with an "X" the level of your pain today. A "0" indicates no pain while a "10" indicates the worst pain you have ever experienced.



Treatment Questionnaire

There are many types of patients and many types of care that can be rendered to a patient.

Please check the following responses that best reflect the type of care you desire so that we can give you the type of care that you want. Select all that are appropriate for you.

- I prefer to have as much work on my problem done as possible in the office instead of at home.
- I prefer to take as much responsibility as possible for my health care.
- I am greatly interested in understanding about my condition.
- I don't really care to understand much about my condition and just want to get better.
- I want to do as much as I can to assist in my health care and am willing to change my:
 - Diet
 - Nutritional support
 - Exercise
 - Lifestyle
- I am interested in my overall health and want to learn more on how to stay healthy.
- I just want my current problem helped.

The following is a partial list of the different procedures we might employ in our office to help improve your health. Please check all that you are interested in and draw a line through any that you are not interested in at this time.

- All of the following at the doctor's discretion
- Anti-aging
- Diet modification
- Exercise – strength
- Food sensitivity
- Spinal manipulation
- Physical therapy
- Cranial technique
- Exercise – cardiovascular
- Exercise – motion
- Home exercise
- Nutritional guidance

Name:

Date:

PERSONAL AND FAMILY HEALTH HISTORY

Any and all physical events that our body goes through leaves obvious, and in most cases, not so obvious findings. Therefore, it is important you take the time and thoughtfully (as well as honestly) answer all of the following questions. Even the ones you believe we have already verbally asked you.

1. Have you ever fractured any bones in your body at any time, ever? (Where and when?) _____

2. Have you ever sprained a joint (hip, knee, ankle, wrist, elbow, shoulder)? _____

3. How do you sleep?
Stomach Very peacefully
Side Restless
Back Hours per night? _____
4. How would you rate your energy level overall, prior to your present findings, on a scale of 0 to 10 (10 being the best)? _____
5. Do you ever experience headaches more than one time per year, if so, please describe how often, location, and duration? _____

6. Do you ever experience back pain more than one time per year, if so, please describe how often, location, and duration? _____

7. With respect to your current problem, if it was left unattended for another 5 years, how do you think it would affect you? Would it just disappear? Get worse? Cause other compensatory problems? _____

8. On a scale of 0 to 10, 10 being the greatest you ever felt in your life, when would you say that it was you felt a 10? And what would you attribute to that? _____

9. On that same scale, when your current problem has been at its absolute worst, where would you have rated yourself? _____

10. What are your current weekly exercise habits? _____

11. What is your typical daily diet breakdown?
 - a. Breakfast (meal & time): _____
 - b. Lunch (meal & time): _____
 - c. Dinner (meal & time): _____

INFORMED CONSENT

Please read carefully

CHIROPRACTIC

Doctors of Chiropractic, medical doctors, and physical therapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment. In particular, you should note:

1. While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.
2. Some types of spinal adjustments of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.
3. There have been rare reported cases of disc injuries following cervical or lumbar spinal adjustment therapy although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic cares contributes to your overall well being. The risk of injuries or complications from chiropractic treatments is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures offered or recommended to me by my chiropractor. I intend this consent form to cover the entire course of treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgement during the course of the treatment which the doctor feels at the time, based up on the facts then known, is in my best interests. I understand that the results are not guaranteed.

I acknowledge I have discussed or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic and/or acupuncture treatment (including spinal adjustment) as well as the contents of this consent.

I understand that the sign in sheet, at the office reception, may be used verify attendance (i.e. in the case of audit procedures). I understand that I may sign by my initials only if I prefer to do so.

Acupuncture

I understand and am informed that in the practice of acupuncture, there are some risks to treatment, including, but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, and stuck or bent needles.

I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Payment

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I understand that Dr. Erik Nabeta's office will prepare any necessary reports to assist me in making collection from the insurance company, and that any amount authorized to be paid to Dr. Erik Nabeta'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 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 to me will be immediately due and payable.

Patient Name: _____ Signature (patient or guardian): _____
Witness: _____ Date: _____



Progressive Chiropractic Centre

Patients with Extended Health Care Insurance

All patients are recommended to check their insurance for coverage of CHIROPRACTIC, ACUPUNCTURE, MASSAGE THERAPY, ORTHOTICS and ORTHOPAEDIC SHOES. The following questions should be asked when calling your insurance company regarding coverage.

Chiropractic

What is the maximum amount paid per visit and per calendar/benefit year for Chiropractic?

Per Visit: \$ _____ Per Calendar Year: _____ % _____

When does the coverage begin?

- After a co-payment or deductible 🍏 How much? _____
- After how many visits _____

Acupuncture

What is the maximum amount paid per visit and per calendar/benefit year for Acupuncture?

Per Visit: \$ _____ Per Calendar Year: _____ % _____

When does the coverage begin?

- After a co-payment or deductible 🍏 How much? _____
- After how many visits _____

Massage Therapy

What is the maximum amount paid per visit and per calendar year for Massage Therapy?

Per Visit: \$ _____ Per Calendar Year: _____ % _____

Do you require a referral from a: Chiropractor: 🍏 MD: 🍏

Orthotics / Orthopaedic Shoes

Do you have coverage for Custom-Made Foot Orthotics Yes 🍏 No 🍏 Orthopaedic shoes Yes 🍏 No 🍏

If yes, what is the amount covered for orthotics? \$ _____ per **calendar** OR **benefit** year.

If yes, what is the amount covered for orthopaedic shoes? \$ _____ per **calendar** OR **benefit** year.

What is the definition of an orthopaedic shoe under your insurance company's guideline?

Do you require a referral from a: Chiropractor: 🍏 MD: 🍏 Podiatrist/Chiropodist: 🍏 Other: 🍏

Who is eligible to dispense the orthotics and/or orthopaedic shoes? Chiropractor: 🍏 MD: 🍏

Podiatrist/Chiropodist: 🍏 Other: 🍏

Do you require a Gait Analysis Report? Yes: 🍏 No: 🍏

HELPFUL HINTS

Always make sure you get the name of the person at the insurance company to whom you spoke to or who gave you this information so you can reach this person in the case of a discrepancy. If you require assistance in contacting your insurance company, please call us at (905) 849-3505 and Dr. Nabeta will gladly assist you.

Insured Employer Name: _____

Insurance Company Name: _____

Group Number: _____ ID Number : _____

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