ALCONA CHIROPRACTIC & NATURAL HEALTH

Dr. Mark Kohut, B.HK, D.C.
1425 7th line
Innisfil, ON L9S 4G3
Telephone/Fax: (705) 431-0505

Personal Information

Name: _____ Date: _____

Address:_____City_____Postal Code _____

Telephone: (Cell)_____ (Bus/Home) _____ Age:_____

Date of birth: M___ D___ Y_____ Weight: _____ Height: _____ Gender: M F

E-Mail Address:_____

Workplace:_____ Occupation:_____

Medical doctor: _____ Address: _____Tel.: _____

Previous Chiropractor: _____ Date of last visit: _____

How did you hear about our office?
( ) Referral – Whom may we thank for referring you to or office?_____
( ) Internet search
( ) Sign
( ) Other - _____

Here at Alcona Chiropractic, we focus on your potential to be healthy! When a patient seeks chiropractic care, it is essential that we are both working towards the same objective. Please take a moment to familiarize yourself with the following terms:

The goal of Chiropractic: To remove any interference from the spine and spinal nerves, in order to allow the brain to fully communicate with the body.

Subluxation: A misalignment or restricted movement in the spine which causes interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to heal and express its health potential.

Adjustment: An adjustment is the specific application of movement used to facilitate the body's correction of subluxation.

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Please try to list your top 3 current stresses in each category:

1. Physical Stresses (poor posture, commuting, accidents, repetitive motions, lacking exercise, etc.)

_____

2. Chemical Stress (unhealthy foods, excessive caffeine, smoking, lacking water intake, etc.)

_____

3. Psychological Stresses (work, relationships, busy schedule, finances, etc.)

_____

Please check anything you are currently experiencing or have experienced in the past. Please add anything not mentioned on the lists.

HEAD
___ headaches
___ trauma
___ vertigo
___ vision problems
___ earache
___ jaw pain
___ sinusitis

CARDIOVASCULAR
___ leg cramps
___ varicose veins
___ poor circulation
___ phlebitis
___ atherosclerosis (hardening of arteries)
___ heart attack
___ stroke
___ high blood pressure
___ low blood pressure
___ heart disease
___ heart murmur
___ pacemaker
___ chronic congestive heart failure
other: _____
_____

WOMEN
___ menstrual problems
___ painful
___ heavy
___ scant
___ pregnancy/due date: _____
___ # of children
___ history of miscarriage
___ menopause
___ hysterectomy

NEUROLOGICAL
___ fainting spells
___ blackouts
___ seizures
___ weakness
___ tingling
___ paralysis
other _____
_____

RESPIRATORY
___ chronic coughing
___ asthma
___ bronchitis
___ emphysema
___ shortness of breath
___ smoking
other: _____
_____

DIGESTIVE / URO-GENITAL
___ poor appetite
___ constipation
___ diarrhea
___ difficult digestion
___ liver
___ gallbladder
___ kidney
___ diabetes (onset: _____)
other: _____

MUSCLES/JOINTS
___ osteoarthritis
___ rheumatoid arthritis
___ fibromyalgia
other: _____
_____

OTHER CONDITIONS
___ frequent colds
___ insomnia
___ anxiety
___ depression
___ epilepsy
___ hepatitis
___ HIV
___ tuberculosis
___ pins/prosthesis
___ thyroid imbalance

OTHER MEDICAL CONDITIONS
_____
_____
_____
_

SURGERY
type/dates: _____
_____

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Current Complaints

If you do not currently have any complaints, please skip to Patient Goals section.

Others please proceed with this section.

1. Condition(s) for which you are seeking relief? _____

   _____ _____

2. When did you first notice the complaint? _____
3. Is this condition getting progressively worse? Yes___ No___ Constant ___ Comes & goes ___
4. Is this condition interfering with your…. work ___ sleep ___ daily routine ___
5. What do you believe is the source of the problem? _____
6. Has there been a medical diagnosis? If yes, what was the diagnosis? _____

   By whom? _____ Address _____

   X-rays or imaging? _____

7. Have you had a similar problem before? If yes, when? _____

Patient Goals

As a result of my chiropractic care, I would like to:

( ) Feel better quickly

( ) Ensure that my health concerns do not become an ongoing problem/impact my future health

( ) Have a healthier body by keeping my nervous system healthy

( ) Live an active, healthier lifestyle to 80, 90, or 100 years of age!

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Informed Consent to Chiropractic Care

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. 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 highly uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

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. Recent studies suggest 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 spinal 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 I 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 consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness Signature**

Name:_____ **Name:**_____

(please print) (please print)

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Payment Agreement & Policy

- Payment is due at the time of service.
- We offer **pre-paid options** for chiropractic care plans. Pre-paid plans provide an administrative **discount** and remove the need for patients to spend time being processed at the front desk each visit.
- We accept the following forms of payment:
  - Cash
  - Cheque
  - Debit Card
  - Credit Card

For patients with insurance plans, we will provide you with the proper documentation to be reimbursed as quickly as possible. We can never guarantee that your insurance company will reimburse your care fees. You are ultimately responsible for the investment into your care at our office.

For patients without insurance coverage, we will print out a yearly statement for income tax deductions at your request.

Cancellation Policy

We require a minimum of 24 hours notice to reschedule, postpone, or cancel an appointment.

Failure to provide **24 hours notice** will result in a **$25** charge. This charge will appear as a 'Missed Appointment Fee' on your next invoice/statement.

By signing this agreement, you are indicating that you understand and agree to the terms of service explained above.

Patient Name :_____

Signature:_____ Date:_____