Dr. Tricia Denunzio, D.C.
145 Huron Road
Goderich, Ontario N7A 2Z7
Phone (519) 440-5071 **Fax** (519) 440-5073
Email: drdenunzio@goderichchiropractic.com

The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods.

Please complete this confidential Health Questionnaire fully and accurately. The more we know about the overall picture of your health the better we will be able to help you.

Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxations in your case.

If you have any questions, please don't hesitate to ask one of our chiropractic assistants for guidance.

Patient Information

Name____

Street Address____

City____________________________ **Postal Code**_____________________

Home Phone______________________ **Cell Phone**______________________

Work Phone______________________ **Work Extension**___________________

E-mail____

Birth date__________________________ **SIN #** _________________________
SIN # is needed if this is an Auto Accident or WSIB claim)

Height___________ **Weight**_________

Gender: ☐ **Male** ☐ **Female**

Your occupation:_____________________ **Employer**_____________________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced**
☐ **Widowed** ☐ **Common Law**

Name of Spouse / Significant Other___________________________________

Experience with Chiropractic Care

Who referred you to this office? ________________________________

Have you ever been adjusted by another Chiropractor? ☐ **Yes** ☐ **No**

Reasons for those visits? ____

____

Were X-Rays taken? ☐ **Yes** ☐ **No**

Did your family receive Chiropractic care? ☐ **Yes** ☐ **No** ☐ **N/A**

Chiropractor's Name: _______________________________________

Approximate date of last visit: ________________________________

Goals for my care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and other for the correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Relief Care – symptomatic relief of pain or discomfort.

☐ Corrective Care – correcting and relieving the cause of the problem as well as the symptoms.

☐ Comprehensive Care – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments.

☐ I want the doctor to select the type of care appropriate to my health status.

____

(Signature) (Date)

What is the purpose of this appointment?

Describe the purpose of this visit____
____

Is the purpose of this appointment related to:
☐ Work ☐ Stress ☐ Sports ☐ Auto ☐ Fall ☐ Chronic ☐ Discomfort Repetitive ☐ Trauma
☐ Check up ☐ Other

Please explain____

How long have you had this condition? ____

Have you had this or similar conditions in the past? (when) ________________________

What activities aggravate your condition? _____________________________________

Has this condition ☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Childcare Responsibilities

☐ Sports ☐ Other Activities
(Please explain)____

Have you seen any other health care providers for diagnosis or management of this condition?

☐ Yes ☐ No (if yes please explain below)

Practitioner's Name____________________ Practitioner's Name____________________
Type of Care________________________ Type of Care________________________
Date__________ Results_____________ Date__________ Results_____________

Are you seeking chiropractic care

☐ As primary intervention ☐ In conjunction with other interventions ☐ As a last resort

My Health Conditions

Please check each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

General
□ Allergy
□ Convulsions
□ Dizziness
□ Fatigue
□ Headache
□ Loss of Sleep
□ Loss of Weight
□ Anxiety/Depression
□ Numbness
□ Cancer
□ Diabetes
□ Thyroid Problems
□ Epilepsy
□ Hyperactivity

Muscle and Joint
□ Arthritis
□ Hernia
□ Low Back Pain
□ Neck Pain
□ Pain between shoulders blades

Numbness or pain in:
□ Shoulders
□ Upper arms
□ Hands
□ Legs
□ Feet
□ Poor Posture
□ Swollen Joints
□ Gout
□ Polio

Gastro-Intestinal
□ Constipation
□ Diarrhea
□ Digestive Dysfunction
□ Gall Bladder Trouble
□ Hemorrhoids
□ Liver Trouble
□ Ulcers

Eyes, Ears, Nose, Throat
□ Asthma
□ Frequent Colds
□ Crossed Eyes
□ Deafness
□ Ear infections
□ Ringing in Ears
□ Eye Pain
□ Vision Problems
□ Nasal Obstruction
□ Sinus

Cardio-Vascular
□ High Blood Pressure
□ Low Blood Pressure
□ Poor Circulation
□ Irregular Heart Beat
□ Ankle Swelling
□ Anemia
□ Arteriosclerosis
□ Stroke

Respiratory
□ Chest pain
□ Chronic Cough
□ Irregular Breathing
□ Wheezing
□ Emphysema

Genito-Urinary
□ Bed-Wetting
□ Painful Urination
□ Prostate Trouble
□ Blood in urine
□ Venereal Disease

Women Only
□ Menstrual Cramps
□ Excessive Menstruation
□ Irregular Cycle
□ Hot Flashes
Are you pregnant?
□ Yes □ No

Other (not listed) ____

Sources of Spinal Stress

To help us determine the cause of your problem, please indicate, on this page and the next, potential sources of spinal trauma.

General Physical trauma

Falls (Details and Dates)

☐ As infant of child ____________________
☐ Down Stairs ______________________
☐ On Ice __________________________
☐ Sports Impact _____________________
☐ Physical Fight _____________________
☐ Other ___________________________

Primary Daily Activities

☐ Sitting ☐ Standing ☐ Walking
☐ Telephone ☐ Driving ☐ Heavy lifting
☐ Desk Work
☐ Manual repetitive work

Exercise

☐ Heavy/Daily ☐ Moderate/Recreational
☐ Periodic

Describe ________________________

Sports and Leisure

Were you, or are you active in any sports?
☐Yes ☐No
Describe _________________________
____
____

Have you ever been hurt or injured in any Of these activities? ☐Yes ☐ No
Describe__________________________
____

Birth

With respect to your own birth process, check all that apply:

☐ Natural ☐ Epidural/Drug-induced
☐ Premature ☐ C-Section
☐ Breech ☐ Cord around neck
☐ Forceps ☐ Prolonged Delivery
☐ Vacuum Extraction ☐ Pulling/twisting by Dr.

Did the mother sustain any falls, accidents, or injuries during pregnancy?
☐Yes ☐ No ☐Unknown

Conditions experienced immediately following birth
☐ Jaundice ☐ Feeding Problems
☐ Respiratory Problem
☐ Displaced or Broken Bones
☐ Other

Birth location:
☐ Home ☐ Birthing Center ☐ Hospital ☐ Other

Auto Accidents

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident, or near collision? ☐ Yes ☐ No
If yes, please indicate approximate dates and severity below:

____

____

**If your chief complaint is in direct response to a motor vehicle accident, please notify our staff, as we will require a separate questionnaire to document your accident and injury.

With respect to the questions below, please provide details where applicable, including dates:

Have you ever been knocked unconscious? ☐ Yes ☐ No
____

Have you ever used crutches, a walker, or cane? ☐ Yes ☐ No
____

Have you had any broken bones? ☐ Yes ☐ No
____

Have your ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐ Yes ☐ No
____

Have you ever had extensive dental or orthodontic work performed? ☐ Yes ☐ No
____

Sprains, strains, dislocations, and years: ____
____

Surgical operations and years: ____
____

Have you ever been hospitalized for any other reason? ☐ Yes ☐ No
____

Family Health History

Family members with diagnosed health problems ____

History of Chemical and Personal Stress

Medications I am currently taking

- ☐ Painkillers _______________________________
- ☐ Anti-Inflammatories ________________________
- ☐ Muscle Relaxants __________________________
- ☐ Blood Pressure Medication _________________
- ☐ Stimulants, Anti-Depressants _______________
- ☐ Tranquilizers, Anti-Anxiety _________________
- ☐ Blood Thinners ____________________________
- ☐ Birth Control pills __________________________
- ☐ Other ____________________________________

You may use back of this sheet for more space

Health Habits

	Heavy	Moderate	Light
Tobacco	☐	☐	☐
Coffee	☐	☐	☐
Alcohol	☐	☐	☐
Recreational Drugs	☐	☐	☐
Prescription Drugs	☐	☐	☐
Exercise	☐	☐	☐
Sleep	☐	☐	☐
Appetite	☐	☐	☐
Personal Stress Levels			
Past	☐	☐	☐
Present	☐	☐	☐

I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary.

I have listed below an emergency and/or alternate contact with whom this office may communicate, if I can not be contacted personally, or in the event of an emergency. Under such circumstances only, this office has my consent to identify me as a patient to the contact named below.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

(Check if applicable) □ I have health coverage and/or accident insurance through ____ .

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.

____
(Signature) ***I have read and understand the above*** (Date)

____
(Signature of legal guardian if under the age of 18 years) (Date)

Emergency Contact
Name of a relative or close friend NOT living at my own address(es)

Name ____

Address ____

Telephone____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, it is in my best interest.

I understand that from time to time Dr. Denunzio may be away for seminars and training. In that event, a locum doctor will be attending to my care and I hereby consent to care by that doctor.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

______________________________	____________________________________
Print Patient's Name	Signature of Patient (or parent/guardian)
______________________________	____________________________________
Witness to Signature above	Date Signed

Dr. Tricia Denunzio D.C.

Goderich Chiropractic Health and Wellness Centre
145 Huron Road, Unit 2
Goderich, Ontario N7A 3K1
(519) 440-5071

Office Policies

Goderich Chiropractic Health & Wellness Centre
145 Huron Rd., Goderich, ON., N7A 2Z7

Dr. Tricia Denunzio, D.C.
Patient Name: _______________________

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and provide you with the best family health care available.

Appointment Scheduling/Missed Appointments Initial_______________

Dr. Denunzio has designed a specific course of action to allow proper care, a must for spinal and postural correction. A personal appointment calendar has been designed for you to save time on each visit. If an appointment must be changed, 24 hours notice is appreciated. All missed appointments should be made up later the same day or within 24 hours.

"No Show" appointments are subject to a $10 charge

Children/Family Initial_______________

Once you understand that the nervous system controls and coordinates all functions of the body and subluxation interferes with nerve flow, we expect that you will want everyone in your family checked. We have a cost effective family program for you. We extend an opportunity for you to have your family checked at our expense within 10 days of starting care.

Financial Agreements Initial_______________

It is your payment that allows us to ***continue*** providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep your financial agreement, ***please inform us immediately to eliminate any misunderstandings.***

Chiropractic Excellence Initial_______________

Dr. Denunzio is occasionally out of the office to attend seminars and conferences to further her education and improve your care. We will build your schedule around those times.

Remember Initial_______________

Spinal correction and healing takes time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with Dr. Denunzio. We want you to get the most from your chiropractic care.

Referrals Initial______________

We believe that health comes from within and that a healthy nervous system is essential for a long healthy life. The health of your loved ones greatly depends on sharing this story with them. If there is someone that you know that you would like to refer to our office, please feel free to do so.

I have read and understand the above policies and agree to abide by them.

Signed_________________________________ Date_____________________________

Witness_______________________________ Date_____________________________

145 Huron Rd., Goderich, Ontario N7A 2Z7
Dr. Tricia Denunzio, D.C.

Terms of Acceptance

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: To eliminate misalignments within the spinal column (subluxations) which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being , not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment provided by others. **OUR ONLY PRACTISE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, ______________________________________ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, Therefore, accept Chiropractic care on this basis. ____

(Signature) (Date)

Dr. Tricia Denunzio, D.C.
Patient Name: _______________________

Fee Schedule

Welcome to our office! Here is a breakdown of the fees for services in our office. If you have any questions please don't hesitate to inquire with our staff.

Consultation and Exam (with 2 Tech Scan)	**Including Examination, an X-Ray Referral (if needed) and Doctor's Report**	**$60.00** ***Children under 2 $40.00**
Consultation and Exam (with 5 Tech Scan)	**Including Examination, an X-Ray Referral (if needed) and Doctor's Report**	**$75.00**
Re-Evaluation (with 2 Tech Scan)	**Regular Fee**	**$29.00**
Re-Evaluation (with 5 Tech Scan)	**Regular Fee**	**$35.00**
Adjustment	**Regular Fee** **Discounted Fee**	**$39.00 Adult Fee** **$35.00 Children / Student** **$29.00 Under 2 years old**
Cold Laser Therapy	**Prices will vary depending on treatment area**	**Starting at $39.00**
Cold Laser & Adjustment	**Discounted Fee**	**$60.00**
Electric Muscle Stimulation	**Regular Fee**	**$10.00**
Kinesiotape	**Prices will vary depending on treatment area**	**Starting at $10.00**
Custom Orthotics	**Including Biomechanical Evaluation & Exam Casting, and/or Properietary GaitScan™ and Custom Orthotic Inserts**	**$450.00**
Shoes	**Shoes when purchased with Custom Orthotics**	**Starting at $50.00**

*****Fees for our professional services are due when rendered. You will be given a receipt to submit to your insurance company if you are eligible for coverage for any of our services*****
*****Missed appointments not made up the same day are subject to a $10.00 fee unless 24 hours notice is given.**
Please Note: This fee is due prior to any care being provided***
If you have any questions regarding our fee system, please feel free to ask any member of our office.

Signed_______________________________ Date___________________________________

Goderich Chiropractic Health & Wellness Centre Dr. Tricia Denunzio, D.C.
145 Huron Rd., Goderich, ON., N7A 2Z7 Patient Name: _______________________