



Goderich Chiropractic
HEALTH AND WELLNESS CENTRE

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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 _____

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 you 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prescription Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Personal Stress Levels

- | | | | |
|---------|--------------------------|--------------------------|--------------------------|
| Past | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Present | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Authorization

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)

Alternate Address

Permanent Temporary Parent Not Applicable

Name _____

Address _____ Apt. # _____

City _____ Prov. _____

Postal Code _____ Telephone _____

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

Fee Schedule

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	\$40.00 Adult Fee \$36.00 Children / Student \$30.00 Under 2 years old
Cold Laser Therapy	Prices will vary depending on treatment area	Starting at \$40.00
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 Proprietary GaitScan™ and Custom Orthotic Inserts	\$450.00
Shoes	Shoes when purchased with Custom Orthotics	Starting at \$50.00

***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

Signed

Date
Office Policy

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. In return you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

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. Please let our front desk Chiropractic Assistant know and changes will be made accordingly.

Broken Appointments

Initial _____

“No Show” appointments are subject to a \$10 charge. Please give 24 hours notice so Dr. Denunzio may service others in need at your time. If appointments are repeatedly missed, we will, regretfully, have to dismiss you from our care.

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.

Interruption of Care

Initial _____

In the unlikely event if it is necessary to discontinue your care for any reason, any outstanding fees become due and payable immediately. If you paid ahead for any of our services and have a credit on your account all returns and refunds are based on our regular retail fees.

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 _____

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)