PERSONAL INFORMATION

Legal Name: _____ DOB: _____ (MM/DD/YY) Age: _____ Sex: _____

Address: _____ City: _____ Postal Code: _____

Tel: Home _____ Business _____ Cell _____

Would you like to receive text message reminders? ☐ Yes ☐ No If Yes, your cell phone provider: _____

Email (optional for receipts): _____ AHC: _____

Emergency Contact (Name, Tel. & Relationship): _____

Occupation: _____ Name of Employer: _____

Is this related to a motor vehicle accident (MVA)?: ☐ Yes ☐ No

If yes, accident date: _____ (MM/DD/YY) Claim/policy #: _____

Adjustor name, fax, phone #: _____

Is this related to a worker's compensation claim (WCB)? ☐ Yes ☐ No

If yes, your claim #: _____

CURRENT HEALTH HISTORY

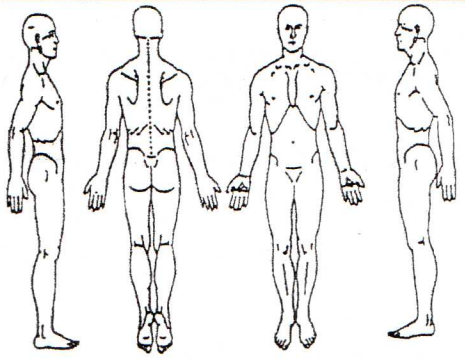
Current concern(s) and when they started- in order of importance:

(1) _____

(2) _____

(3) _____

Mark where the pain is.



Have you had a physical in the last year? ☐ Yes ☐ No

Are you currently exercising? ☐ Yes ☐ No

When did the pain start? _____

Rate your pain: (None) 1 2 3 4 5 6 7 8 9 10 (worst)

Does the pain travel/move? _____

What makes it worse? _____

What makes it better? _____

Have you had this injury before? ☐ Yes ☐ No If yes, when? _____

Have you had previous treatment? ☐ Yes ☐ No If yes, who? _____

How much sleep do you get per night? _____

Do you wear orthotics? ☐ Yes ☐ No If yes, for how long? _____

List any medical conditions you are diagnosed with: _____

_____

List any medications/supplements you are currently taking: _____

_____

_____

FAMILY HEALTH HISTORY

Have you or anyone in your family had any of the following (specify whom):

Heart Disease _____ High blood pressure _____

Cancer _____ Diabetes _____

Stroke _____ Other _____

PAST HEALTH HISTORY

List any previous **surgeries** and the year(s) they occurred: _____

_____

List any previous **fractures** and the year(s) they occurred: _____

_____

List any previous **accidents/traumas** and the year(s) they occurred: _____

_____

EXTENDED INSURANCE

Do you have Alberta Blue Cross, Manulife, Sun life, Greenshield, Great West Life, or Chambers of Commerce Insurance?

☐ Yes ☐ No

If yes, indicate which company and your associated ID/group #'s: _____

_____

MacNeill Chiropractic and Wellness Centre will bill your insurance carrier on your behalf when we can verify that payment will be received by the clinic directly. In the following circumstances you will be required to pay at the time of service:

- When you do not have any insurance that will cover the service
- When your insurance carrier sends payment directly to you or requires you to pay and submit your expenses
- When your coverage does not pay 100% or has been used up (you are responsible for the copayment)
- When a product is custom made (deposit is required before ordering)
- If you start treatment before approval for a car insurance or work injury claim (MVA or WCB)

Canadian Chiropractic Protective Association

Informed Consent to Chiropractic Treatment

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 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; there is a stroke already in progress. However, you are being informed of this reported associated because a stroke may cause serious neurological impairment or death, the possibility of such injures occurring in association with upper cervical adjustment is extremely remote;

(C) There are rare reported cases of disc injuries identified following cervical and lumbar spine adjustments, although no scientific evidence has demonstrated how 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.

Dated this _____ day of _____, 20 _____

X _____

Patient or Legal Guradian Signature

X _____

Witness of Signature (Chiropractor)

X _____

Patient Name (printed)

X _____

Witness Name (printed)

Canadian Chiropractic Protective Association

Informed Consent to Acupuncture Care (Form- AC)

Please read carefully.

(A) I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, and including moxibustion, cupping, and/or electroacupunture by the above-named doctor or another duly authorized doctor in the clinic.

(B) 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, possible perforation of internal organs, and stuck or bent needles.

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

(D) 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 upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

(E) I have read this consent form. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

Dated this _____ day of_____, 20 _____

X _____ X _____

Patient or Legal Guradian Signature Patient Name (printed)

Missed Appointment and Cancellation Fees

We require 4 hours' notice for rescheduling or cancelling an appointment; if less than 4 hours is given, your account will be charged. A fee will also be charged to your account for all missed chiropractic appointments. For your convenience and as a courtesy, we provide you with 24 hour voicemail services and appointment reminder services. **Please note that we do not give reminder calls.** By signing this agreement you are aware of our office policy.

X _____

Patient or Legal Guardian Signature