New Patient Questionnaire - Chiropractic

Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Name & phone number of your emergency contact *

Email Address: *

Are you a student or pensioner? *

Are you covered under Work Safe, Department of Veterans Affairs TAC? *

If you answered yes, what is the claim number?

Have you had any x-rays or scans taken? If so, where? *

Have you had any cosmetic implants or pacemaker surgery? *

Do you have any medical conditions? Are you on any medications? If so please list them. *

Where on your body are you feeling pain? *

- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Legs
- ☐ Back (upper)
- ☐ Back (lower)
- ☐ Hip Area
- ☐ Hands
- ☐ Feet
- ☐ Face/Head

How did you hear about us? *

- ☐ Family
- ☐ Google
- ☐ Friend
- ☐ Doctor
- ☐ Other

***Please note that missed appointments with a minimum of 2 hours notice will be charged for.**

Patient signature:

Date *

Day Month Year

Consent to Chiropractic Care

Chiropractic care is recognized as being an effective and safe method of care for many conditions. You must recognize, however, that there are risks associated with all health care procedures. Please read carefully the following risks that you should be informed about.

I acknowledge that I have discussed with Dr Julia Higgins, Dr Jessica Mibus, Dr Laura Keating, Dr Michael Landry, or any other chiropractor working in this clinic, the rare risks associated with my care, including but not limited to:

- Muscle and joint soreness or strains
- Nausea and dizziness
- Fractures
- Vascular injuries
- Disc injuries
- Strokes, or stroke-like episodes (risk: 1: 1,000,000 to 1: 10,000,000)
- Exacerbation and/or aggravation of my underlying condition

I acknowledge that I have had the opportunity to discuss my proposed chiropractic care, including the opportunity to ask questions about the nature, extent and purpose of the proposed treatment. I have been given sufficient time to make the decision of giving consent for the care to proceed. I acknowledge that I am aware of, and understand the potential risks and I appreciate that results are not guaranteed.

I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care, but I wish to rely on the doctor to exercise judgment during the course of my treatment and to act in my best interests at all times.

Should I for any reason require emergency medical attention (i.e. CPR or Ambulance attendance) I authorise the clinic to act on my behalf.

I hereby acknowledge my consent to the performance of the proposed chiropractic care*. I understand that I can withdraw my consent at any time.

Medical Record Release Authority:

I intend to give my consent to release any relevant medical results to this clinic, including X-rays, CT, MRI and blood test results. I understand I can withdraw my consent at any time.

* Chiropractic care may involve the use of dry needling therapy. Dry Needling is a valuable treatment for acute and chronic pain. Like any medical procedure, there are possible complications including but not limited to; infection, hematoma (bruising), paraesthesia (tingling sensation) which may continue for a brief moment. In the case of needling in the chest wall region, there is a rare possibility of pneumothorax (air in the chest cavity). Whilst complications are extremely rare, they must be considered prior to treatment. Patients must inform practitioners about medical conditions such as pregnancy, pace makers, joint replacements, blood borne infectious diseases, breast implants or the use of blood thinners prior to treatment. You can alter this consent at any time.

Do you consent to the use of dry needling therapy *

Patient Signature (Parent or Guardian to sign if under 18)

Date

Day Month Year

Signature of treating Chiropractor

Date

Day Month Year