1733 Industrial Road • Cambridge, ON N3H 5G7 • Tel: 519-624-8437 • Fax: 519-653-7009 • health@bacdox.com • bacdox.com

Welcome to our clinic!

This sheet will give you a brief explanation of what to expect on your first visit. If you have any questions, please feel free to ask!

<u>Forms</u>: The forms you complete are an important first step in diagnosing your condition. They provide us with an understanding of your condition and your medical history that are important in helping us arrive at a diagnosis. If you are not sure how to complete any part of the forms, please ask at the reception desk.

<u>Video</u>: After you have completed the forms you will be seated in our consultation room to watch a short video which may answer some of your questions about chiropractic.

<u>History</u>: Your chiropractor will ask you a series of a questions about your current condition as well as your medical history. These questions will help us diagnose your condition. Medical history may not seem relevant, but previous or existing conditions may affect both your diagnosis and/or your treatment plan.

<u>Examination</u>: Following your history taking, you will be shown to an examination room. You may be given a gown to wear (please leave your undergarments on) so that the doctor can see your spine and related musculature. During the examination your chiropractor will perform various tests that will help determine your diagnosis. With an accurate diagnosis, your treatment will be more effective.

<u>X-rays</u>: Depending on your age, medical history and condition the doctor may recommend that x-rays are taken. If you have had x-rays taken recently, please inform the doctor.

<u>Treatment</u>: Depending on your condition and whether or not x-rays were taken, the doctor may conclude your initial visit with a short treatment aimed at relieving some of your discomfort. A full treatment, however, cannot be performed until your next visit. At this time the chiropractor will explain your diagnosis to you and make recommendations about your care. At the conclusion of your first visit, your chiropractor will make a recommendation as to the timing of your next appointment. You can schedule this at the reception desk.

<u>Fees</u>: The cost for the initial consultation is $80 for adults and $70 for children and seniors. If x-rays are required at the time of your initial examination, they are included in the initial visit cost. On future visits, the fees are $40 for adults and $35 for children and seniors. Payment is due at the conclusion of each visit and may be made with cash, cheque, Visa, MasterCard or Interac.

Date:

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PERSONAL and CONFIDENTIAL INFORMATION

Name:__________________________ ☐ Female ☐ Male Date of Birth (dd/mm/yyyy):____________

Address:____

City:______________**Province:**_______**Postal Code:**__________**Email:**____________________

Contact Information: Home:______________**Work:**______________**Cell:**______________

Occupation:________________**Marital Status:**________**Name of Partner:**________________

How did you hear about our office?______________**Referred by:** ____________________

Previous Chiropractic Care? ☐ Yes ☐ No **Name of Previous Chiropractor:** ____________ **How long ago?** ________

Family Physician: ______________ **Is it OK to send your physician updates regarding your condition?** ☐ Yes ☐ No

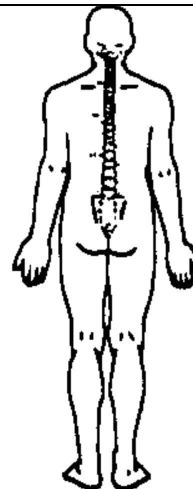
Is this condition related to: **Work?** ☐ Yes ☐ No **Has your employer been notified?** ☐ Yes ☐ No
Motor Vehicle Accident? ☐ Yes ☐ No **Date of Injury:**__________

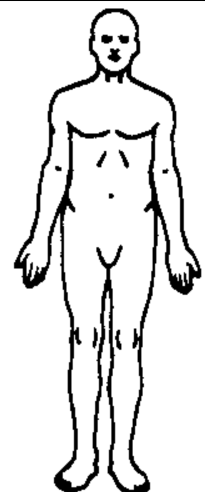
Previous X-rays, MRI or other tests : ☐ Yes ☐ No **When and where were they taken?**______________
Recent Blood work: ☐ Yes ☐ No **Date:** __________**Results:** ____________________
Approximate date of your last physical examination: __________**Results:**
____

Within the past 6 months have you experienced any **infections and/or fever?** ☐ Yes ☐ No
weight gain or loss? ☐ Yes ☐ No
pain that wakes you up at night? ☐ Yes ☐ No
Do you smoke or have you in the past? ☐ Yes ☐ No **Packs/day:** ________
Do you drink alcohol? ☐ Yes ☐ No **Drinks/day:** ________
Exercise (please circle): None Occasional Daily **Current Sports/Athletic Activities:** ____________
Approximate body weight: __________ **Approximate height:** ______________

Please indicate the area of your symptoms on this diagram using the symbols listed below:

++++ Dull or Aching
//// Stabbing or Sharp
==== Stiff & Tight
XXXX Burning
NNN Numbness
**** Pins & Needles





Please list any previous surgeries, illnesses, injuries, fractures, motor vehicle accidents, etc:_________________

____

List all medications: (prescriptions, vitamins, birth control, aspirin, Advil, Tylenol, etc.): _____________________

____

Have you or a family member ever been diagnosed or told you have any of the following? Please check the appropriate box and provide relevant details.

Back Problems	☐ Yes	☐ No	☐ Family______________________
Heart Disease	☐ Yes	☐ No	☐ Family______________________
Diabetes	☐ Yes	☐ No	☐ Family______________________
Tuberculosis	☐ Yes	☐ No	☐ Family______________________
Cancer	☐ Yes	☐ No	☐ Family______________________
Epilepsy	☐ Yes	☐ No	☐ Family______________________
Stroke	☐ Yes	☐ No	☐ Family______________________
Osteoporosis	☐ Yes	☐ No	☐ Family______________________
Arthritis	☐ Yes	☐ No	
Mental Disorder	☐ Yes	☐ No Condition: ________________________	
AIDS/HIV	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	

SYSTEMS REVIEW

Please *circle* any conditions that you are *presently* experiencing and underline those that you have experienced in the *past*.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
	Asthma	Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbances	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhoea
Weakness	Palpitations	Blood in stool
Slurred Speech	Cold hands or feet	Gallbladder/jaundice
Numbness in the face	Varicose veins	Colitis
EENT	**MUSCLE & JOINT**	**WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders	Miscarriages
Enlarged glands	Swollen joints	Complications with pregnancy
Hearing disturbances	Spinal curvature	Currently Pregnant? Y / N

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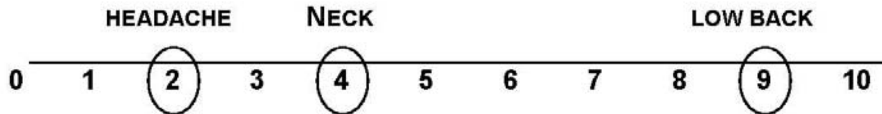
QUADRUPLE VISUAL ANALOGUE SCALE

Name ______________________________ Number __________ Date ______________

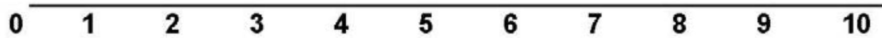
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

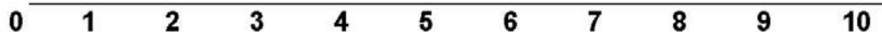
EXAMPLE:



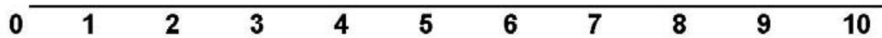
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

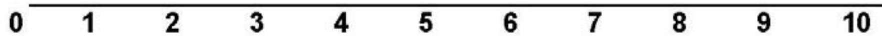


3. What is your pain AT ITS BEST (How close to “0” does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _______%

4. What is your pain AT ITS WORST (How close to “10” does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _______%

Dr Dale Harrison ☐ Dr. Suzanne Scott ☐ Dr. Amy Brown ☐