OAKVILLE CHIROPRACTIC & FAMILY HEALTH

Dr. Terrence J. Lemay B.Sc., D.Ac., D.C.
Oakville Chiropractic and Family Health
2525 Old Bronte Road, Suite # 380
Oakville, Ontario L6M 4J2
289-837-3777

Name: _____ Birthdate (mm/dd/yy): _____ / _____ / _____ Age: ____

Address: _____ City:_____Prov:_____ Postal Code:_____

Email address:_____ Cell Phone:_____

Home Phone: _____ Work Phone:_____ Ext: _____

Type of Work: _____ Gender: ☐ M ☐ F Weight: _____ Height: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Number of Children: _____

Who may we thank for referring you to our office: _____

Current Health

Main/Current Health Concern(s): _____

Other professionals seen for this Concern? ☐ Y ☐ N *Type of professional seen:* _____

Type of Treatment: _____ *Results:* _____

When did this begin? _____ *Has it occurred before?* ☐ Y ☐ N

What makes this worse? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying down ☐ Cold ☐ Dampness ☐ Other

What makes it better: ☐ Bed rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Chiropractic ☐ Other

Character of Discomfort: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles/Numb
☐ Constant ☐ Intermittent ☐ Burning

*What else have you tried to get rid of this?*_____

Indicate by circling the number on the scale the severity of your discomfort (if applicable):

1 2 3 4 5 6 7 8 9 10
Least ⟷ Worst

Does this problem interfere with: Work ☐ Y ☐ N Family/Social Time ☐ Y ☐ N Hobbies/Sports ☐ Y ☐ N

Current medications: ☐ Nerve Pills ☐ Painkillers/Muscle relaxants ☐ Blood Pressure Medication
☐ Insulin ☐ Other:

Do you currently wear custom orthotics/shoe inserts? ☐ Y ☐ N

*On a scale from 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem:*_____

Past Health History

Major Surgery/Operations: _____

Previous: ☐ Childhood Trauma ☐ Motor Vehicle Accidents ☐ Sports Injuries
☐ Work Injuries ☐ Hospitalization (other than above)

Family Health History

*Name of Family Physician*_____

Please indicate any health issues that are present in your Parents _____

*Siblings*_____

Do any family members suffer from the same condition (as you)? ☐ Y ☐ N *Who?*_____

Have your children ever had a spinal check-up? ☐ Y ☐ N *If yes, where and when* _____

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Below is a list of symptoms or diseases that may seem unrelated to the purpose of your treatment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the **past 6 months**, even if they do not seem related to your current problem:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling extremities
- ☐ Stress

Musculoskeletal
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty chewing/Clicking jaw
- ☐ General Stiffness

Satisfaction with Diet
- ☐ Highly Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Intake
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ White sugar
- ☐ Cigarettes

Do you have a regular exercise program? ☐ Yes ☐ No

How often do you exercise?
- ☐ 1-2 times per week
- ☐ 2-4 times per week
- ☐ 4 or more times per week

Sleeping Position
- ☐ Back
- ☐ Side
- ☐ Stomach

Type of mattress:_____

Age of mattress: _____

Is it comfortable? ☐ Yes ☐ No

Type of pillow: _____

Age of pillow:_____

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Eyes, Ears, Nose, Throat
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Lifestyle Stress Levels
- ☐ High
- ☐ Moderate
- ☐ Very Little
- ☐ None

Check any of the following diseases you have had:
- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer
- ☐ Mental Health Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Psoriasis

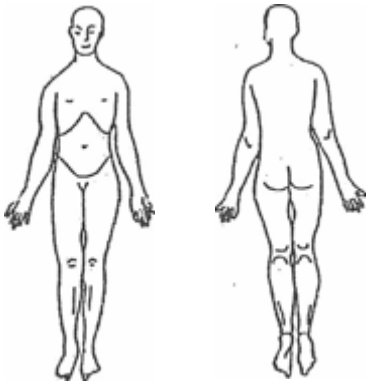
Gastro-Intestinal
- ☐ Black/Blood Stool
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after Meals
- ☐ Colitis

Male/Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

Female
When was your last period?_____

Are you pregnant?
☐ Yes ☐ No ☐ Not sure

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discoloured Urine



Please outline on the diagram the area of your discomfort and any radiation of pain.

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Why Chiropractic Care?

People go to a chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Preventative Care). These are the three types / phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three types / phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Preventative Care – life enhancements and wellness care
☐ Corrective Care – removing cause and remodelling soft tissue
☐ Relief Care – band-aid care only
☐ Check here if you want the doctor to select the type of care appropriate for your condition

Please read carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from my insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

We require 24-hours notice for appointment changes and cancellations. Advance notice allows us to better accommodate our patients on the waiting list. Notice is acceptable by voice-mail and email and will be confirmed by reply from someone at Oakville Chiropractic and Family Health. While we make every effort to remind our patients of appointments in advance, it is the patient's responsibility to maintain his or her schedule and confirm all appointments at least 24-hours prior. Extenuating circumstances will be reviewed on a case-by-case basis and can be forgiven.

☐ Yes ☐ No I may be contacted by email
☐ Yes ☐ No I would like to receive receipts, statements and appointment reminders by email.

_____ _____

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE
(Parent / Guardian if under 16 years)

_____

DATE (mm/dd/yy)

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Chiropractic care is provided to normalize and balance the functioning of your body. Our approach incorporates examination, diagnosis and treatment of your condition, focusing primarily on the correction of spinal subluxations. These are regions of the spine that are not functioning optimally. Our spines were meant to move; when motion is restricted, the associated vertebrae (spinal bones), muscles, and most importantly, nerves cannot perform as they were designed to in a natural mobile spine. Your nerves are the conduits by which your brain sends messages to your entire body. When their function is impaired through subluxations, this can interfere with the mental impulses sent by the brain, thus inhibiting the repair and regeneration of normal tissue. By correcting this condition with an adjustment, chiropractic enables your body to function optimally and in a balanced way. Should your condition not be amenable to chiropractic, you will be referred to the appropriate health care professional.

Chiropractic is very safe form of treatment, however, in the past there have been incidents of injury to the cervical vertebral artery. This has caused stroke, or stroke like occurrences which are usually temporary in nature. Current statistics indicate that the chances of this happening are between one in one million and one in a half million (for perspective, that is about the same as getting hit by lighting). Your chiropractor will perform tests on you, with or without x-rays, to minimize this risk to yourself. Chiropractic has been shown to be the safest form of manipulation and is a powerful tool in helping you regain and maintain your health.

I, _____, having read and understood the above statements, give consent to be examined and treated by Dr. Terrence Lemay.

Signature:_____

DATE (mm/dd/yy) : _____

Parent/Guardian Consent Form (if applicable – the child under 16)

I, _____as parent/guardian, give consent for _____ to be examined and treated by Dr. Terrence Lemay.

_____ _____

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE
(Parent / Guardian if under 16 years)

_____

DATE (mm/dd/yy)

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture and, as needed, other procedures by Dr. Terrence Lemay.

I understand that in the practice of acupuncture, there are some risks including, but not limited to: minor bleeding/bruising, minor soreness, nausea, fainting, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications.

I wish to rely on Dr. T. Lemay to exercise judgement during the course of treatment, which based on the facts then known, is in my best interest. I understand that the results are not guaranteed.

I have read the above consent form. I have had an opportunity to ask questions, 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 considerations and extend this consent to the acupuncture colleagues within this clinic.

Note to Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

☐ I hereby state that I am **NOT** pregnant nor is there any possibility that I may be pregnant. I also understand it is my responsibility to inform the doctor prior to treatment if I become pregnant in the future.

☐ I hereby state that I **AM** pregnant. I also understand it is my responsibility to inform the doctor prior to treatment if I become pregnant in the future.

_____ _____

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE
(Parent / Guardian if under 16 years)

_____

DATE (mm/dd/yy)

Required by the Canadian Chiropractic Protective Association