Dr. Cameron Edgar
Dr. Maja Edgar

EDGAR
Family Chiropractic

PATIENT INTRODUCTION
(PLEASE PRINT)

Name: _____ _____ Gender: Male□ Female□
First Last

Date of Birth: (Year) _____ (Month) _____ (Day) _____

Home Address: _____

City_____ Province: _____ Postal Code_____

Home Telephone: ( ) _____Cell Number: ( ) _____

Work Telephone: ( ) _____ Email: _____

I would like to be added to the clinic email list for important clinic notices and one monthly newsletter: YES NO

Family Dr.: _____ Phone Number: ( ) _____

REFERRED BY: _____

MVA

Is this a result of a Car Accident? Yes □ No □

Date of Accident: (Year) _____ (Month) _____ (Day) _____

Name of Auto Insurance: _____

Policy Holder's Name: _____

Policy Number: _____ Claim No.: _____

Have you been to any other Rehab Clinic: Yes □ No □

If yes, date of first and last Visit: _____

INSURANCE COVERAGE (EXTENDED HEALTH CARE)

Do you or your spouse or guardian have Extended Health Care coverage? Yes □ No □

Name of the Insurance Company: _____

Policy Holder's Name: _____

Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy or Plan#: _____Group ID#: _____

Cert. #: _____

WSIB

Is this a result of a Work Accident? Yes □ No □

Employer's Name: _____ Tel Number: _____

WSIB Claim Number: _____ **Date of Accident**_____

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Dr. Maja Edgar and Dr. Cameron Edgar

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HEALTH HISTORY FORM

For your information :
An accurate health history is important to ensure that it is safe for you to receive therapy treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law. You will be asked to provide written authorization for release of any information.
Name: _____Date: _____

Please check or fill in the appropriate information

What is your primary complaint? _____

Head/Neck
- ☐ **headaches**
- ☐ **migraines**
- ☐ **sinus problems**
- ☐ **ear problems**
- ☐ **vision problems**
- ☐ **vision loss**
- ☐ **contact lenses**
- ☐ **glasses**
- ☐ **hearing loss**

Cardiovascular
- ☐ **high blood pressure**
- ☐ **low blood pressure**
- ☐ **CCHF**
- ☐ **heart disease**
- ☐ **heart attack**
- ☐ **stroke /CVA**
- ☐ **poor circulation**
- ☐ **phlebitis**
- ☐ **varicose veins**
- ☐ **pacemaker or similar device**

Respiratory
- ☐ **chronic cough**
- ☐ **shortness of breath**
- ☐ **smoke _____**
- ☐ **bronchitis**
- ☐ **asthma**
- ☐ **emphysema**

Muscles / Joints
- ☐ **neck _____**
- ☐ **low back _____**
- ☐ **mid back _____**
- ☐ **upper back _____**
- ☐ **shoulders _____**
- ☐ **arm L/R _____**
- ☐ **leg L/R _____**
- ☐ **knee L/R _____**
- ☐ **other _____**

Digestive/Uro-genital
- ☐ **difficult digestion**
- ☐ **constipation**
- ☐ **liver / gall bladder**
- ☐ **kidney / bladder**

Other Conditions
- ☐ **loss of sensation**
- ☐ **diabetes (onset: _____)**
- ☐ **epilepsy**
- ☐ **allergies _____**
- ☐ **colds**
- ☐ **insomnia**
- ☐ **cancer _____**
- ☐ **arthritis _____**
- ☐ **hepatitis _____**

Infections
- ☐ **Hepatitis**
- ☐ **Skin conditions**
- ☐ **TB**
- ☐ **HIV**

Woman
- ☐ **Pregnant (Due: _____)**

What is your general health status?
_____
_____

Current Medications: _____
Condition it treats: _____
Surgery: _____ Date: _____
Nature: _____
Injury: _____ Date: _____
Nature: _____

Primary Care Physician: _____
Address: _____
Present Involvement in Other Health Care: Yes No
If yes, please specify: _____
_____
_____

Other Medical Conditions (eg: digestive conditions, gynaecological conditions, hemophilia, etc): _____
_____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment): _____
_____

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

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Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____20____
Signature of Chiropractor

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent for Acupuncture Care FORM - AC

Please Read Carefully

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

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.

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

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 judgment 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.

I have read the above 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.

N.B. 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.

READ BEFORE SIGNING

_____	_____	_____
Date Signed	**Print Patient's Name**	**Signature of Patient (or parent/guardian)**

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CHIROPRACTIC/ACUPUNCTURE/MASSAGE THERAPY (PAYMENT OPTIONS AND AGREEMENT)

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you as quickly and efficiently as possible. These are the most common services we provide:

Initial Consultation/Examination: Introduction to the clinic, discuss your health concerns/injuries, review your health history, ascertain the nature of your health concerns/injuries, and determine a plan of management.

Subsequent Treatment: Reduce inflammation, decrease pain, increase range of motion, adjust/manipulate the spine, soft tissue (massage) therapy, exercise prescription, acupuncture, expedite the healing process and provide relief.

NOTE: The **Ontario Health Insurance Plan (OHIP**) does not provide coverage for our services.

FORMS OF PAYMENT: We accept cash, debit, Visa, MasterCard or personal cheques.

INSURANCE AND THIRD PARTY PAYERS: Your care may be covered by employer group Extended Healthcare Benefits, Auto Insurers (for Motor Vehicle Claims), and the Workplace Safety and Insurance Board (WSIB) for injuries sustained at work.

Unless you have been injured in a motor vehicle accident, or had a work related injury, or your extended health allows for direct billing, all professional services that are rendered are **charged to the patient receiving care**. We will supply you with statements, reports and other documents to help you receive reimbursement from your Extended Healthcare insurer. In the case of a motor vehicle accident or a work-related injury, all fees will be directly billed to the Auto Insurer or WSIB respectively. Should your extended health insurance company send payment for unpaid services to your home, these payments must be submitted to the clinic within one week.

We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "unusual and customary" charges, etc. other than to supply information.

CANCELLATION POLICY: A minimum of 24 hours notice is required for cancellation of appointments. Otherwise, a missed appointment fee may be charged to your account.

SPECIAL ARRANGEMENTS: We would not deny anyone the benefits of chiropractic care or our other services because of their inability to pay our published fees. Please speak to Dr. Edgar regarding individual consideration of fees.

Any outstanding balances are billed monthly and considered past due 10 days after the invoice date, or when special arrangements are not met. If a second invoice must be issued there may be a $5 surcharge added. Balances older than 30 days will accrue interest at 2% per month. Returned or NSF cheques are subject to a $30 service charge.

Please ask if you have any questions about this agreement, or if your ability to comply with its provisions changes.

PATIENT AGREEEMENT: I have read, understood, and agreed to this financial agreement.

_____ _____

Patient Signature **Date**

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MEDICAL RELEASE FORM

I, _____ hereby authorize the release of any and all information pertaining to my health status to Edgar Family Chiropractic. I also grant Dr. Edgar permission to disclose any and all health and medical information and findings to other professionals in the medical field, insurance companies, lawyers, employers, etc., as he deems fit.

Date:_____

Patient's Name:_____

Patient's Signature:_____

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