Hamilton Back Clinic p.c.

Name: ______________________ Address: ______________________

City: ______________________ Postal Code ______________________

Phone: ______________ Sex: M___ F___ Date of Birth: ______________
Mon / Day / Year

E-mail: ______________________________________

Emergency Contact: Name/ Phone: ______________________________

Name of Family Physician: (MD) ______________________________

Employer: ______________________ Employer Phone: ______________

Name of Extended Health Insurance Co: ______________________

***Please indicate what your coverage includes:***

Chiropractic ☐ Physiotherapy ☐

Acupuncture ☐ Foot Orthotics ☐ Don't Know ☐

Who may we thank for referring you? ______________________________

Reason for visit: ______________________ When did this occur: ______________

Due to auto / work injury? ______________________________

How would you describe the pain? ______________________________

Is pain constant? _______ Does pain travel? _______ Where? ______________________

What makes condition worse? Sitting ☐ Walking ☐ Bending ☐ Other ☐

What makes condition better? Ice ☐ Heat ☐ Rest ☐ Exercise ☐ Meds ☐

What medications are you currently taking? ______________________________

Any previous trauma (falls, accident) ______________________________

Any previous surgeries? ______________________________

Any food / drug allergies ______________________________

Have you seen any other doctors for this condition? ______________________________

PLEASE FILL OUT ALL 4 PAGES

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## MEDICAL HISTORY

**Please ☑ if you have a *family history* of the following:**

- ☐ Cancer
  (Type) ____________________
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Lung Disease
- ☐ High Cholesterol / Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Thyroid Disease

☐ At the best of my knowledge I **am pregnant**
☐ At the best of my knowledge I **am not pregnant**
Should you become pregnant please advise the doctor at your next visit.

**Please ☑ if you have had or currently suffer from the following:**

- ☐ AIDS/HIV
- ☐ ANAEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ANOREXIA
- ☐ APPENDICITIS
- ☐ BLEEDING DISORDERS
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ BOWEL DISEASE
- ☐ BULIMIA
- ☐ CANCER
- ☐ EARACHES
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ FRACTURES
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEADACHES
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HIGH CHOLESTEROL/ BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BACK PAIN
- ☐ LUNG DISEASE
- ☐ MUMPS
- ☐ MONONUCLEOSIS
- ☐ MULTIPLE SCLEROSIS
- ☐ MUSCULAR DISEASE
- ☐ MENTAL DISEASE
- ☐ MIGRAINES
- ☐ NECK PAIN
- ☐ OSTEOPOROSIS
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTHESIS
- ☐ RHEUMATIC FEVER
- ☐ PACEMAKER
- ☐ SCARLET FEVER
- ☐ SORE MUSCLES
- ☐ STROKE
- ☐ STD'S
- ☐ SKIN DISORDERS
- ☐ TENDONITIS
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ TUMOURS
- ☐ ULCERS
- ☐ OTHER
  ____________________
  ____________________
  ____________________
  ____________________
  ____________________

The information I have given in both the patient history and medical history are correct to the best of my knowledge.

____________________ Signature

____________________ Date



2200 Rymal Rd. E. Hamilton, Ontario L0R 1P0

Hamilton Back Clinic p.c.

## Informed Consent

Chiropractic, Active Release (ART), Medical Acupuncture, and Physiotherapy are very safe forms of health care. It is in your best interest to be educated so that you can make an informed decision about your health.

Although it is uncommon, there is a chance of rib injury, muscle strain and superficial bruising and blood vessel damage that may occur with any of the above treatments. Although the risks exist, all patients at Hamilton Back Clinic are examined thoroughly to help prevent the incidence of such events from happening.

I am also aware that I can discontinue treatment at any time.

____________________________ Patient Signature

________________ Date



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# Payment Schedule

## Chiropractic / Acupuncture

### Initial Visit

(Standard) $75
(Student) $65

### Standard Visit

(Standard) $40

### Standard Visit with Medical Acupuncture

(Standard) $45

### Laser Therapy $45

### Physiotherapy

Initial Visit $80
Follow Up Visit $60

** I understand payment is due on the same day that I have been treated.

Patient Signature: ____________________ Date: ____________________

## Missed Appointments

If you must cancel an appointment, we require that you notify us **6 hours** prior to your scheduled appointment. There will be a **$15.00** fee for a missed appointment.

Revised Jan. 23, 08