Brost Chiropractic & Wellness

Phone: 403.520.5265
Fax: 403.520.5266
120, 817 - 19th St NE, Calgary AB T2E 4X5
getadjusted@brostchiro.com
www.brostchiro.ca

Completion of this confidential form is required by all Brost Chiropractic & Wellness Centre patients on their first visit so the practitioners providing your care are accurately informed. We also ask that you keep us up-to-date with this information as it changes, as this is part of your permanent record.

It is our clinic policy to keep all of our records completely confidential. No copy of your file shall be released unless the request is accompanied with your signed consent. All of your original records will remain at Brost Chiropractic & Wellness Centre for ten years from the last date seen and/or 10 years after age 18, after which time they may be shredded and destroyed.

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Alberta Health Care # _____ Date of Birth: Month _____ Day _____ Year _____

□Male □ Female

Home Phone: _____ Cell Phone: _____

Parents Name(s): _____

Siblings Names & Ages: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

How did you hear about our office? _____

Who may we thank for referring you to this office? _____

Have you been treated by a Chiropractic Doctor before?

□ No □ Yes - Chiropractor: _____

Tel: _____ Last Appt: _____

Why did you leave care? _____

_____

Medical Doctor: _____

Tel: _____

Last Appt: _____

Clinic Name/Location: _____

The Human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependant upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interferes with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

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What is the primary reason for your visit? _____

_____

Is this due to a: □ Automobile Accident □ Work-related Injury □ Personal Injury Case □ None/Other_____

The overall severity of your complaints/concerns is:

□ N/A □ Mild □ Mild to Moderate □ Moderate □ Moderately Severe □ Severe

The overall frequency is: □ Occasional □ intermittent □ frequent □ Constant

On a scale of 0 to 10, how would you rate your child's pain/symptoms today?

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst Possible

If your child's symptoms change, when are they worse? □ Morning □ Afternoon □ Evening □ Night

What aggravates your child's condition? □ Sitting □ Standing □ Bending □ Lifting □ Walking □ Lying Down □ Cold

□ Dampness □Other: _____

What relieves your child's condition? □ Bed Rest □ Ice □ Heat □ Massage □ Medication

Other: _____

Has your child had recent treatment for this condition? □ No □ yes - Please list dates/doctors

_____

_____

Has your child had the same or similar problems in the past? □ No □ Yes – please describe

_____

_____

Do you have any additional complaints/concerns/health problems? □ No □ yes – please describe:

_____

_____

Does your child suffer from any other condition than the one you are consulting for us now? □ No □ yes – please describe:

_____

_____

Did you carry to Full Term? □ Yes □ No – how many weeks were you _____

Were there any complications during pregnancy? □No □ yes – please describe

_____

_____

Ultrasounds during this pregnancy? □ No □ Yes – how many? _____

Medications during this pregnancy? □ No □ Yes – please list _____

Smoking during this pregnancy? □ No □ Yes – how much? _____

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Alcohol during this pregnancy? □ No □ Yes – how much? _____

Place of Birth: □ Hospital □ Home □ Birthing Centre □ Other _____

Type of Birth: □ Vaginal □ C-Section – □ Anesthesia □ Epidural – what this planned ? □ Yes □ No

Was your labor induced? □ No □ Yes – why? _____

Birth Trauma: □ Doctor Assisted □ Twisting / Pulling □ Vacuum Extraction □ Forceps

What position did you deliver in? □ Laying on back □ Squatting □ Other _____

Birth Weight: _____ lbs _____ oz Length: _____ APGAR scores: _____ _____

According to the National Safety Council approx 50% of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured in playgrounds annually. Can you recall any such jolts, falls or traumas to your child? □ No □ Yes – please explain _____

_____

Is/Has your child been involved in any high impact or contact type activities:

□ Soccer □ gymnastics □ baseball (t-ball) □ martial arts □ hockey □ lacrosse □dance

□ Other (please list) _____

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery

□ Broken Bones □ Other: _____

Previous: □ Childhood Traumas: _____

□ Motor Vehicle Accidents: _____

□ Hospitalization (other than above): _____

_____

Drugs your child takes now: (including over the counter & prescription): _____

_____

_____

Please indicate any health issues that are present in your family:

Parents: _____

_____

Siblings: _____

_____

Does any member of your family suffer from the same condition? □ No □ Yes – whom? _____

_____

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Is there anything else you would like us to know: □ No □ Yes

_____
_____
_____
_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of Chiropractic Care. Check any of the following your child has had in the past:

Nervous System
□Nervous
□Numbness
□Paralysis
□Dizziness
□Confusion / Depression
□Fainting
□Convulsions / Seizures
□Cold / Tingling Extremities
□Stress

Musculo-Skeletal
□Low Back Pain
□Gas / Bloating After Meals
□Pain Between Shoulders
□Heartburn
□Neck Pain
□Black / Bloody Stool
□Arm Pain
□Colitis
□Joint Pain / Stiffness
□Walking Problems
□Difficult Chewing / Clicking Jaw
□General Stiffness
□Scoliosis

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

Genito-Urinary
□Bladder Trouble
□Painful / Excessive Urination
□Discolored Urine

Gastro-Intestinal
□Poor / Excessive Appetite
□Excessive Thirst
□Frequent Nausea
□Vomiting
□Diarrhea
□Constipation
□Hemorrhoids
□Liver Problems
□Gall Bladder Problems
□Abdominal Cramps
□Digestive Problems

EENT
□Vision Problems
□Dental Problems
□Sore Throat
□Ear Aches
□Hearing Difficulty
□Stuffed Nose
□Asthma
□Allergies
□Chronic Colds

General
□Fatigue
□ Loss of Sleep
□ Fever
□ Headaches
□ Significant Weight Loss
□Growing / Back Pains
□Pneumonia
□Mumps
□Influenza
□Rheumatic Fever
□Small Pox
□Pleurisy
□Polio
□Chicken Pox
□Rubella
□Arthritis
□Tuberculosis
□Diabetes
□Epilepsy
□Whooping Cough
□Cancer
□Mental Disorder
□Anemia
□Heart Disease
□Lumbago
□Measles
□Thyroid
□Eczema
□Colic
□Bed Wetting
□Temper Tantrums
□ADD/ADHD

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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 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 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 Enhancement and Wellness Care

□ Corrective Care – Removing Cause and Remodeling 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

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

CANCELLATION POLICY

Time slots are valuable. Therefore we require 12 hours notice of cancellation or your account will be billed ½ of the appointment value.

_____ please initial your acknowledgment of this policy

Extended Health: Parent 1 _____ Parent 2: _____

My signature below indicates that I attest that the information indicated here in these forms is correct.

_____ _____ _____

Parent/Guardian Signature **Printed Name** **Date**

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We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the c circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for chiropractic and other services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send patients informational material and newsletters about our practice and pertinent health issues.
- For the purpose of marketing to external or internal media, I consent to the publication of my name, photograph & any testimonials given either verbal or written.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of chiropractic treatment.

Financial information may be collected and verified in order to make arrangements for the payment of services.

Detailed Patients Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of treatment.
- To other chiropractors and specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other chiropractors and specialists if the patient, with their consent, has been referred by us to the other chiropractor or specialist for treatment.
- To other chiropractors and specialists where those chiropractors have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if we have referred the patient, with their consent, to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our Chiropractic practice, qualified potential purchasers may be granted access as part of the due diligence to process all patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

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Chiropractors are regulated by the Alberta College of Chiropractors who which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

Brost Chiropractic sends out text reminders for every appointment. Our reminders are two way communications enabled.

Cell # _____

☐ **Check here if you do NOT wish to receive text messages.**
You may opt out at anytime. *Standard text message rates may apply. Please check with your carrier*

☐ **YES, please send me email reminders _____**

☐ Day Before ☐ Morning Of

☐ **YES, please add me to the Birthday List. Email: _____**
*You may opt out at anytime.

☐ **YES, please send me your monthly e-newsletter. Email: _____**
*You may opt out at anytime.

☐ **YES, please me e-receipts. Email: _____**
requested benefit receipts will be printed, as we are unable to email these

☐ **NO - do not send me any correspondence. I have the right to change my mind. At that time I will provide my written approval.**

At any time, you can change your preference, by written correspondence, or the unsubscribe link at the bottom of our emails/texts

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Patient Name	Signature of Patient/Parent/Guardian	Date

_____
Print Name of Parent/Guardian