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## **Outline of Procedures for New Patients**

### **Step One**

All new patients are requested to fill out a “Confidential Patient Introduction”.

### **Step Two**

Your first “Consultation” with the doctor to discuss your health problems.

### **Step Three**

You will receive a “Chiropractic Examination” to determine if chiropractic care is appropriate for your condition.

### **Step Four**

An in-depth, chiropractic assessment of your nerve and energy system is needed to determine how well your brain is communicating with your body. As well, if indicated, x-rays will be taken to visualize the location of spinal problems. If previous x-rays are available, please ask staff for an x-ray release form and take this to your x-ray clinic.

### **Step Five**

If your case requires immediate attention, first day Chiropractic procedures will be administered.

### **Step Six**

You will be advised as to a time you can return for your “Report of Findings” when your doctor will inform you of your examination results and whether or not your case has been accepted. If accepted your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage available.

### **Step Seven**

You will be advised as to a time you can return for a “Dr.’s Report” with the Doctor/staff. This report will enable you to get better faster – thus saving you time and money. Bring your family and friends so that they, too can learn about wellness.

### **Step Eight**

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

### **Step Nine**

The charge for your first visit today is \$65.00. How will you pay today? Cash, cheque, visa or debit (please circle).

***\*\*To save time and allow us to better serve you, please complete all questions on the next pages. \*\****

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Business / Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Circle One: Married Single Divorced Separated Other No. of children \_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who may we thank for referring you to this office: \_\_\_\_\_

How will you be taking care of your account?  Cash  MC  Visa  Debit  Cheque

**E-Mail address:** \_\_\_\_\_

**CURRENT HEALTH CONDITIONS**

Current Complaint(s): \_\_\_\_\_

Other Doctors seen for this condition:  Yes  No Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has this condition occurred before?  Yes  No

Is condition:  Job Related  Auto related  Home Injury  Fall  Other please explain: \_\_\_\_\_

Date of accident \_\_\_\_\_ Time of Accident: \_\_\_\_\_

What aggravates your condition?  Sitting  Standing  Bending  Lifting  
 Walking  Lying Down  Cold  Dampness  Other: \_\_\_\_\_

What relieves your condition?  Bed Rest  Ice  Heat  Massage  Medication  
 Other \_\_\_\_\_

Is it getting:  Worse  Constant  Comes/Goes  Better

Character of Pain:  Sharp  Dull  Ache  Pins & Needles  Numb  
 Burning  Constant  Intermittent

Please describe how it feels when this problem is at its worst. \_\_\_\_\_

Please place an X on the grade indicating the severity of your pain. (10 being the worst)

1 2 3 4 5 6 7 8 9 10

Compare this problem at its worst with a time when you feel great. How does this problem at its worst interfere with:

Your ability to work? \_\_\_\_\_

Your ability to enjoy your family and social time? \_\_\_\_\_

Your ability to enjoy your hobbies or sports? \_\_\_\_\_

At your worst, how old does it make you feel? \_\_\_\_\_

If you don't get this problem corrected, do you think it will get worse over the next 5 years?

Yes  No

Drugs you now take:  Nerve Pills  Painkillers/Muscle Relaxers  Insulin  
 Blood Pressure Medicine  Other: \_\_\_\_\_

Do you suffer from any other condition other than that for which you are now consulting us?  
\_\_\_\_\_

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem.

\_\_\_\_\_ Have you had X-rays taken in the last six months?  Yes  No

If yes, where? \_\_\_\_\_ What area of the body? \_\_\_\_\_

## PAST MEDICAL HISTORY

Please check or describe:

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  
 Broken Bones  Other: \_\_\_\_\_

Previous: Childhood Traumas \_\_\_\_\_ Sports Injuries \_\_\_\_\_  
Motor Vehicle Accidents \_\_\_\_\_ Work Injuries \_\_\_\_\_

Hospitalization (other than above): \_\_\_\_\_

Previous Chiropractic Care: No  Yes  Doctor's Name and approximate date of last visit: \_\_\_\_\_

Have you ever been on a spinal health maintenance program? Yes  No  Do you currently do anything to maintain the health of your spine and nervous system? \_\_\_\_\_

## FAMILY HEALTH HISTORY

Does any member of your family suffer from the same condition?  NO  YES Whom? \_\_\_\_\_

Have your children ever had a spinal check-up?  No  Yes If yes, where and when? \_\_\_\_\_

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 diseases you have had:

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder
- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema

### Check any of the following you have had in the past six months:

#### Musculo-Skeletal Code

- 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

#### Nervous System Code

- Nervous
- Numbness
- Paralysis
- Dizziness

- Forgetfulness
- Confusion/ Depression
- Fainting
- Convulsions
- Cold/ Tingling Extremities
- Stress

**C-V-R Code**

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

**General Code**

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

**EENT Code**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose

**Gastro-Intestinal Code**

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**Male/Female Code**

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

**Genito-Urinary**

- Bladder Trouble
- Painful / Excessive Urination
- Discolored Urine

**Females Only**

When was your last period?

\_\_\_\_\_

Are you pregnant

- Yes
- No
- Not Sure

**Intake**

**Amount**

- |                                      |       |
|--------------------------------------|-------|
| <input type="checkbox"/> Coffee      | _____ |
| <input type="checkbox"/> Tea         | _____ |
| <input type="checkbox"/> Alcohol     | _____ |
| <input type="checkbox"/> Cigarettes  | _____ |
| <input type="checkbox"/> White Sugar | _____ |

**Personal Satisfaction with Diet**

- Highly Satisfied
- Dissatisfied
- Highly Dissatisfied

**Do you have a regular exercise program?**

- High
- Moderate
- Very Little

## **CHIROPRACTIC OFFICE POLICY**

**A 24 hour notice must be given for missed, cancelled and/or rescheduled appointments or \$35.00 will be charged to your account.**

**Missed, cancelled and/or rescheduled appointments affect everyone. People on the waiting list who urgently need to be seen appreciate your consideration and courtesy.**

**I understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment to the Doctor.**

**Our office does not carry account balances. Our office requires payment in advance or payment at each visit.**

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**By signing below, I hereby agree to the terms and conditions set out above.**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Witness**

**Date:** \_\_\_\_\_

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon facts then known, is in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present condition.

**TO BE COMPLETED BY PATIENT:**

\_\_\_\_\_  
Print Patients Name

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date signed

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