

Confidential Patient Record Card

Name: Mr Mrs Ms Miss Dr _____
(Please circle) (Last) (First) (Middle)

Address: _____ **Postal Code:** _____

Telephone Number: _____ (Home) _____ (Work)

Pager/Cell Phone: _____ **Email:** _____

Date of Birth: (MM/DD/YYYY) _____ / _____ / _____ **Age:** _____ **Sex:** _____ **Marital Status:** (S, M, D, W) _____

Spouse's Name: _____ **Number & Ages of Children:** _____

Emergency Contact Name: _____ **Telephone:** _____ () _____

Medical Doctor: _____ **Do you consent to your findings being shared with your Medical Doctor?** _____ (Y or N)

Occupation/Profession: _____ **Employer:** _____

CareCard Number: _____ **Private Health Insurance:** _____

How did you find out about our Clinic? _____ **Referred by:** _____

Previous Chiropractic care? _____ (Y or N) **By Whom?** _____ **When?** _____

Have you had X-rays taken? _____ (Y or N) **If yes, Date Taken:** _____ **Area/Results:** _____

Do you have reason to believe you are pregnant? _____ (Y or N) **Due Date:** _____ **PLEASE REQUEST PREGNANCY FORM**

Are you claiming under Worker's Compensation? _____ (Y or N) **Claim Number:** _____

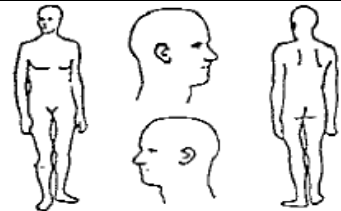
Are you claiming under I.C.B.C? _____ (Y or N) **Claim Number & Adjuster Name:** _____

Smoker? ____ **If yes, how many pack per day?** ____ **Drink coffee?** ____ **If yes, how many cups per day?** ____ **Drink soft drinks?** ____

If yes, diet or regular? ____ **How many cups per day?** ____ **Drink Tea?** ____ **If yes, how many cups per day?** ____ **How many cups of**

water per day? ____ **Exercise regularly?** _____ (Y or N) **Eat a balanced diet?** _____ (Y or N) **Sleep at least 8 hours a day?** _____ (Y or N)

Please briefly describe complaint(s) and mark your area of pain on the diagram on the right:



My pain/discomfort is now: _____ **0** ----- **5** ----- **10**
(indicate with an "X" on the scale) (No pain) (Worst pain)

Have you had difficulty with any of the following? (Please mark all that apply with P for in the past & N for now & explain, if needed, in the space below):

- Aneurysm _____ Stroke _____ Cancer _____ Heart Conditions _____ Chest Pains _____ Diabetes _____ Polio _____ Epilepsy _____ Multiple Sclerosis _____
- Muscular Dystrophy _____ Lupus _____ Hepatitis _____ VD/STD _____ HIV/AIDS _____ Psoriasis _____ Eczema _____ Anorexia/Bulimia _____ Anemia _____
- Unexplained Bleeding _____ High Blood Pressure _____ Low Blood Pressure _____ Thyroid Conditions _____ Shortness of Breath _____ Tuberculosis _____
- Emphysema _____ Pleurisy _____ Pneumonia _____ Bronchitis _____ Allergies _____ Asthma _____ Sinus Conditions _____ Loss of Smell _____
- Sore Throat _____ Difficulty Swallowing _____ Stomach Conditions _____ Indigestion/Reflux _____ Ulcers _____ Liver Conditions _____
- Gall Bladder Conditions _____ Intestinal Gas/Bloating _____ Constipation _____ Diarrhea _____ Kidney Conditions _____ Urinary Tract Conditions _____
- Menstrual Irregularity _____ Menstrual Cramps/Pain _____ Reproductive Disorders _____ Fatigue _____ Cold Sweats _____ Sleeping Difficulty _____
- "Nerves" _____ Depression _____ Irritability _____ Loss of Memory _____ Dizziness _____ Fainting _____ Loss of Balance _____ Concussion _____
- Ringing in Ears _____ Hearing Loss _____ Ear Pain _____ Fever _____ Vision Problems _____ Wearing Glasses _____ Light bothers Eyes _____
- Jaw Clicking _____ Clenching/Grinding Teeth _____ Headaches _____ Flushing of Face _____ Twitching in Face _____ Head feels too Heavy _____
- Grating in Neck _____ Muscle Spasms in Neck/Back _____ Tight Neck/Shoulder Muscles _____ Osteoporosis _____ Painful Joints _____ Arthritis _____
- Pins & Needles in Hands/Feet _____ Swollen Hands/Feet _____ Cold Hands/Feet _____ Foot Problems _____ Restless legs _____ Numbness _____
- Broken Bones _____ Dislocated Joints _____ Herniated Disc(s) _____ Pinched Nerves _____ Other _____
- Childhood Conditions:* Measles _____ Mumps _____ Chicken Pox _____ Whooping Cough _____ Scarlet Fever _____ Diphtheria _____ Croup _____
- Rheumatic Fever _____ Typhoid Fever _____ Ear Infections _____ Tubes in Ears _____ Chronic Illness _____

Special Considerations: _____

Have you ever had any falls, accidents or injuries? _____ (Y or N) **When?** _____

If yes, please explain _____

Have you ever had surgery? _____ (Y or N) **When?** _____

If yes, please explain _____

Are you presently taking any medication? _____ (Y or N) **If yes, please give type, dosage & what it is for** _____

Informed Consent To Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- c. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment and options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.



Dated this _____ day of _____, 20_____.

Patient Signature/Legal Guardian

Witness Signature

Patient Name (Please print)

Witness Name (Please print)

CCPA 11/2008



Terms of Acceptance

When a patient seeks chiropractic health care and we accept such a patient for care, it is essential for both to be working towards the same objectives. Chiropractic has only one goal: to eliminate spinal misalignments (subluxations) that interfere with the body's natural healing ability. The Chiropractor's sole purpose is to restore health through the natural flow of energy in the nervous system, to give the body the maximum opportunity to heal itself.

It is important to understand what to expect from chiropractic in order for you, the patient, to determine whether it may be of benefit to you. A Chiropractor conducts a specialized spinal examination and analysis for the express purpose of determining whether there is evidence of spinal subluxations. When such subluxations are found, chiropractic adjustments are given to restore proper spinal alignment and function. Due to the complexities of nature, no Chiropractor can promise you specific results – this depends on the recuperative powers of your body. We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what this disease is called, we do not offer to treat it. Nor do we offer advice on the treatment prescribed by others. Every chiropractic patient should be mindful of his/her own symptoms and should secure a medical opinion if he/she has any concern as to the nature of his/her illness or injury. In rare cases, underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The Chiropractor, of course, will not give a chiropractic adjustment if he/she is aware that such a condition exists. It is the responsibility of the patient to make it known if he/she is suffering from any latent pathological defects, illness, or deformity that might not otherwise come to the attention of the Chiropractor. The patient should not look to the Doctor of Chiropractic for in-depth diagnostic procedures other than to find subluxations. This is the most important difference between chiropractic and medicine.

Our only practice objective is to promote natural health through the release of maximum nerve energy. Our only treatment is by specific chiropractic adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
PRINT NAME

All questions regarding the Chiropractor's objectives pertaining to my care in this office have been answered to my satisfaction.

I, therefore, accept chiropractic care on this basis.

SIGNATURE

DATE

If applicable, _____
SIGNATURE OF PARENT OR GUARDIAN



**ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS
TO OPTED-OUT PRACTITIONERS**

I, _____(Beneficiary) authorize the Medical Services Plan of BC to pay **Dr. Stacey Michelle Rosenberg, D.C.** (Practitioner) directly for all reimbursements for benefits payable to me under the Medical and Health Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Services Plan of BC, which will be directed to **Dr. Stacey Michelle Rosenberg, D.C.** (Practitioner) to be applied against any outstanding monies I owe for services provided.

MSP Practitioner#: 21127 MSP Payment#: 21127

Name of Patient: _____ (Please Print)

PHN of Patient: _____ (Care Card Number)

Dear Patient:

This form allows the above named practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursed by MSP.

Signature of Patient: _____

Date Signed: _____

