Gibsons Chiropractic

Todays Date: ___________________

Confidential Pregnant Patient Record Card

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

Address:____ **Postal Code:**_______________

Telephone Numbers: (_________)_________________________ (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: (________)**_______________________

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:**______________________

Doctor/Midwife:_________________________ **Do you consent to your findings being shared with your Doctor/Midwife?** ______ (Y or N)

Date of Last Medical Appointment:______________________________ **Date of Last Physical:**_______________________

How many weeks gestation is your baby? __________________________________ **Due Date:**___________________________

How many pregnancies have you had? Vaginal Delivery______ **Caesarean Section**______ **Forceps**______ **Vacuum extraction**______

Anaesthesia used? ______ (Y or N) **If yes, what type**____

Please explain any complications with this or past pregnancies ____

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)

The reason for this visit is a result of: Breech presentation ______ **Backache of Pregnancy** ______ **Headache** ______ **Trauma** ______

Please briefly describe complaint(s):

____

____

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 "✓" all that apply & explain if before (B) or during (D) pregnancy, 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 and/or vitamins?____ (Y or N) **If yes, please explain**_______________________________

____

Patient is responsible for full payment of services if medical insurance is not valid.
One full day's notice is required for cancellation of appointments.

____
(Patient's Initial)

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.

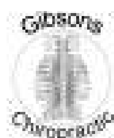
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

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



721 Winn Rd., PO Box 1063, Gibsons BC V0N 1V0; Phone/Fax 604 886-7080
Email: Chiropractor@dccnet.com, Web: www.GibsonsChiropractic.com

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 PRACTITITIONERS

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: ________________________

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