Dr. Tiffany Huggins

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Oakville Chiropractic Centre

OUTLINE OF OFFICE PROCEDURES & POLICIES

Note: *If you have been involved in motor vehicle accident or this is a work place injury, please advise front desk staff to ensure you are filling out the correct paperwork for your claim.*

1. Please ensure you have signed in at our office register today and each subsequent visit.
2. All new patients will be asked to complete a personal health history regarding current and past health problems.
3. You will have a consultation with a doctor to further discuss your health and wellness concerns.
4. The doctor will complete neurological, orthopaedic, and chiropractic diagnostic testing specific to your condition.
5. The doctor will advise you of any necessary additional procedures such as laboratory tests and x-rays.
6. If your case requires immediate attention, emergency care will be administered, or referrals made.
7. After history and exam procedures, you will be advised as to a time you may return to meet with the doctor for your 'Report of Findings' where the doctor will review pertinent findings regarding your case, as well as provide you with information regarding potential treatment options. It is at this visit you may discuss financial arrangements, insurance coverage, and other information as it applies to you.

PERSONAL INFORMATION

First name:_____ Last name:_____

Birth date: Day:_____Month: _____Year: _____Age:_____

Home Address:_____

City:_____Province:_____Postal Code:_____

Telephone #: Home:_____ Work:_____Cell:_____

Email Address:_____

Emergency Contact Name:_____Phone Number:_____

Sex (please circle): Male / Female / TM2F / TF2M Height:_____ Weight:_____

Marital Status (please circle): Single Married Separated Divorced Widowed

Number of Children:_____ Ages:_____ Birth Type (women only): vaginal/c-section/other:_____

Occupation/Employer:_____Type of Work:_____

Primary Physician:_____Phone number:_____

May we contact your primary physician about your case? Yes / No

How were you referred to our office?_____

CURRENT HEALTH CONDITION

Current Complaint(s), if any:_____

Have you seen anyone else about this condition? Yes / No Who:_____

Treatment administered: _____Results:_____

Onset—how/when did this happen?_____

If this was an accident, please list the date/time:_____

Is the condition: Job-Related? Auto-Related? Home Injury? Fall? Sports-Related? Other:_____

Duration—how long has it bothered you?_____

Does the pain refer/travel to other areas, if yes, where?_____

How frequent is the pain you experience: Constant Intermittent Morning Night Other:_____

Please rate your pain out of 10 (0=no pain, 10=worst pain imaginable) _____/10 (current) _____/10 (at onset)

How would you describe your pain: Ache Sharp Shooting Numbness Tingling Burning Throbbing

Other:_____

What makes your condition feel better?_____

What makes your condition feel worse?_____

Is it getting: better, worse, or staying the same?_____

What daily and recreational activities is it most interfering with:_____

Do you have any additional conditions you currently suffer from other than your main complaint? Yes / No

If Yes, please expand:_____

Please list any medications and/or vitamins/supplements you currently take and why:

Medications:_____

Vitamins/Supplements:_____

PAST HEALTH HISTORY

Have you ever… (if yes, briefly explain)

- ➔ been hospitalized? Yes / No_____
- ➔ had any mental disorders? Yes / No_____
- ➔ broken any bones? Yes / No_____
- ➔ had any strains/sprains? Yes / No_____
- ➔ been in a car accident? Yes / No_____
- ➔ had a serious fall? Yes / No_____
- ➔ had any surgery? Yes / No_____
- ➔ used or currently use alcohol, tobacco, or recreational drugs? Yes / No _____
- ➔ any allergies? Yes / No_____

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

□Pneumonia	□Mumps	□Influenza	□Visual Impairment
□Rheumatic Fever	□Small Pox	□Pleurisy	□Hearing impairment
□Polio	□Chicken Pox	□Arthritis	□HIV/AIDS
□Tuberculosis	□Diabetes	□Epilepsy	□MS
□Whooping Cough	□Cancer	□Mental Disorder	□Crohn's/ Colitis
□Anaemia	□Heart Disease	□Lumbago	□Liver Conditions
□Measles	□Thyroid	□Eczema	□Stomach Conditions

CHECK ANY OF THE FOLLWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

□Low Back Pain
□Leg/ Hip/ Knee/ Foot Pain
□Pain Between Shoulders
□Neck Pain
□Arm/ Shoulder/ Hand Pain
□Joint Pain/ Stiffness
□Walking Problems
□Difficulty Chewing/ Clicking Jaw

FEMALES ONLY

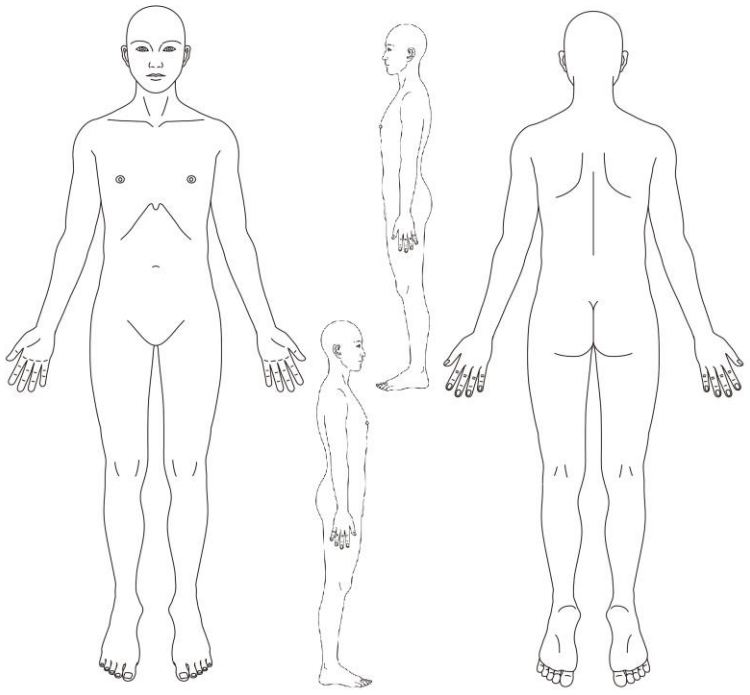
When was your last period?
Are you pregnant?
□Yes □No □Not Sure
□Menstrual Irregularity
□Menstrual Cramping
□Vaginal Pain/ Infections
□Breast Pain/ Lumps

NERVOUS SYSTEM CODE

□Nervousness/ Anxiety
□Numbness
□Paralysis
□Dizziness
□Forgetfulness
□Confusion/ Depression
□Fainting
□Convulsions
□Cold/ Tingling Extremities
□Stress
□Subluxations

Please outline on the diagram any areas of your discomfort.

⊗= Numbness X= Pain + = Stiffness



GENERAL CODE

□Fatigue
□Allergies
□Loss of Sleep
□Fever
□Headaches
□Decreased Wellness

C-V-R CODE

□Chest Pain
□Shortness of Breath
□Blood Pressure Problems

□Irregular Heartbeat	□Heart Problems	□Lung Problems/ Congestion
□Varicose Veins	□Ankle Swelling	□Stroke

INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic Adjustments and adjunct procedures including but not limited to various modes of physical therapy, soft tissues and trigger point techniques, electromodalities, spinal decompression, and if deemed necessary diagnostic x-rays performed on me by the Chiropractors of Oakville Chiropractic Centre.

I understand I have an opportunity to discuss with the doctor and/or additional office personnel, the nature and purpose of my treatment. I understand that results cannot and are not guaranteed.

I further understand and am informed that, as with all health care, in the practice of Chiropractic there are some slight risks associated with treatment including but not limited to muscle strains, sprains, disc injury, and stroke. I do not expect the doctor to be able to anticipate 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 on the facts then known, to be in my best interests.

I have read the above consent. I have had the opportunity to ask questions about this consent and by signing below agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also give permission to Oakville Chiropractic to contact me via the email address which I have provided regarding appointments, promos, and any office news and events.

APPOINTMENT REMINDERS:

How would you like to receive your appointment reminders?

☐ Phone call ☐ Email ☐ Text Message

CANCELLATION POLICY (PLEASE READ AND INITIAL):

Oakville Chiropractic Centre does provide email reminders for appointments. I acknowledge that 24 hours notice is required should I choose to cancel or reschedule my appointment. If less than 24 hours notice is given, or if I fail to show up for my scheduled appointment, I understand one of the following charges will be applied to my account:

- ☐ **A cancellation fee of half the initial exam** should I cancel my appointment with less than 24 hours notice.
- ☐ **A full appointment fee** should I not show up to my scheduled appointment without notice

Please confirm that you have read the cancellation policy and agree to pay any outstanding balances_____ **(initial here)**

SERVICES & FEES:

We take pride in providing top notch service to our patients. We also don't want any surprises for you when it comes time for payment. Here is a list of our fees with respect to the services we offer.

Initial Examination	$90
Adjustment	$46
Adjustment and Modality	$54
Spinal Decompression	$100-$130
Adjustment and Soft Tissue	$65
Adjustment and Exercises Instruction	$65
Progress Evaluation	$30
Reactivation Exam	$90

PATIENT CONSENT:

I have read through the consent, cancellation policy and services/fees. The information I have provided is all to the best of my knowledge.

Date: _____

Patient Name (Please Print):_____

Patient Signature (Please Sign):_____

OCC Witness Name (Please Print):_____

OCC Witness Signature (Please Sign):_____

EXTENDED HEALTH INFORMATION:

Insurance Company:_____

Policy Number:_____

Member ID:_____

Coverage (*Please select all that apply*) Chiropractic $_____Orthotics $_____

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Centre