McLeod Family Chiropractic

Date _____

Health Profile For:_____
(Family Name) (First) (Initial)

Address_____City_____Postal Code_____

Health insurance plan_____ Other Health insurance plan:(spouse or parent)_____

Date of Birth (mm/dd/yyyy):_____ Email: _____

Home Telephone:_____ Work Telephone:_____

Cell phone #:_____Employer: _____

Daily Duties:_____Referral source_____

(Optional) Marital Status: M Common Law S D W

Name of Spouse_____Number of children (with ages)_____

Have your children had a spinal check up yet? ___Yes ____No

Name of Emergency Contact:_____Telephone(Res.)_____(Bus.)_____

At McLeod Family Chiropractic we focus on your ability to be healthy. Answering the following questions will give us a profile of the specific stresses you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

Physical Stresses

Yes No

____ ____ Have you ever been involved in a motor vehicle accident ?(even if you were not injured)
_____

____ ____ Have you had any falls or accidents? (Please list all)
_____

____ ____ Have you had any falls or accidents as a child?
_____

____ ____ Do you currently play any sports? _____
____ ____ Have you had any sport injuries? _____
____ ____ Have you had a concussion? _____
____ ____ Were you under regular chiropractic care as a child?_____
____ ____ Does your job require lifting, repetitive motions, or excessive standing or sitting?
____ ____ Have you had any surgeries?_____
____ ____ Have you had any serious health conditions? *(please list)* _____

Chemical Stresses

Yes No

____ ____ Did / Do you smoke? How many / day?_____
____ ____ Did / Do you drink alcohol ? How many / week? _____
____ ____ Do you drink coffee? How many / day?_____
____ ____ Do you eat out frequently or eat excessive amounts of junk food?_____

LIST any drugs you are presently taking (prescription, non-prescription, otherwise)
_____
_____
_____

Emotional Stresses

On a scale from 1—10 (10 = worst) what is your current stress level?
*Work?*____ *Home?*____ *Financial?*____ *Other?*_____

On a scale of : Very Poor, Poor, Good, or Excellent describe your :
*Diet*_____*Exercise*_____ *Sleep*_____ *General Health*_____

Have you had previous chiropractic care? ____Yes ____ No When? _____ Reason ?_____

Chiropractor's Name: Dr. _____Were X-rays Taken? ____ Yes ____ No

Chief Concerns and Other Symptoms

What is your major complaint presently ? _____

How did this start? ———————————————————————————--

How long have you had this condition ?_____

Have you had a similar condition in the past ? _____Yes ____No

What aggravates your condition? _____

What gives you relief?_____

Do you have pain, numbness or tingling in your:

____Arms ____Hands ____Head ____Back of thigh ____Legs ____Feet

Is this getting progressively worse? ____No ____Yes ____It is constant ____It comes and goes

Pains can be described as:

____Sharp ____Dull ____Burning ____Tightness ____Throbbing ____Radiating

This condition interferes with:

___Work ___Sleep ___Walking ___Running ___Sitting ___Hobbies ___Leisure ____Sports

Other doctor (s) seen for this condition:_____

On a scale of 1 to 10 (10 being the highest) rate your commitment to correcting this problem?_____

Additional Notes:

Family History *(please check those that apply)*

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	_____	_____	_____	_____	
Mother's side	_____	_____	_____	_____	

Are you currently dealing with any of the above noted conditions ? Yes _____ No Other_____

Women only if applicable: Is there a possibility you may be pregnant? _____ Yes _____ No.

For doctor only:

Systems Review ———————————————————————————————————

_____

_____

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www.mcleodfamilychiro.ca

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

Doctor's of chiropractic who perform spinal adjustments are required to advise patients of potential risks associated with such treatment. While rare, some patient's may experience short terms of aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques.

There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustments and the occurrence of stroke. The possibility of such injuries resulting from an upper cervical spinal adjustment is extremely remote. There are reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Spinal adjustments have been subject of government reports and multi-disciplinary studies and have been found to be safe and effective. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatments, medications and procedures given for the same symptoms.

I acknowledge, I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

Patient Name: _____ Signature: _____

(please print)

Date Signed: _____ Witnessed by (staff): _____

EXTENDED HEALTH CARE INSURANCE FORM

PLEASE FILL OUT THIS FORM AND BRING IT TO OUR OFFICE ON YOUR NEXT VISIT

410 6th St. south, Lethbridge, AB. T1J-2C9 • Phone: 403-394-1177 • Fax: 403-394-1171 **www.mcleodfamilychiro.ca**

McLeod Family Chiropractic

PATIENTS NAME _____

Insurance Company Name: _____

Name of the policy holder: _____Date of Birth_____
(dd/mm/yyyy)

Employer _____

Group/Contract/Policy # _____ID #_____

CALL YOUR INSURANCE COMPANY

Date you called the Insurance company : _____

Name of person who gave you the information: _____

Contact # of person who gave you the information:_____

ASK THE FOLLOWING QUESTIONS

1. Does my policy cover chiropractic care? ☐ Yes ☐ No *(If no : Then you do not have to complete the rest of this form)*

2. Amount of coverage allowed per year per person ? $_____

3. What is my benefit year ? (*Example: Jan1—Dec 31*) _____

4. Is there a maximum amount per visit ? _____ (*is it a dollar amount or a percentage amount?)*

5. Do I have to pay a deductible ? ☐ Yes ☐ No If yes: How much is it ? _____
   Is the deductible yearly? Yes ☐ No ☐
   Has it been paid ? ☐ Yes ☐ No

6. Does my policy cover X-rays at a chiropractic office ? ☐ Yes (What is the amount?_____) ☐ No

7. Is my yearly limit exclusively for chiropractic or is it included with a group of services? *(i.e. physiotherapy,massage, acupuncture, orthotics etc ?)* _____

FURTHER INFORMATION

Do you have dependants, spouse , or children who are covered by this insurance ? ☐ Yes ☐ No

We can photocopy your benefit card to record all the names and insurance ID # . OR you can write them down in the space provided

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Are you covered by any other insurance plan? ☐ YES ☐ NO If yes: *(please fill out another extended health insurance form)*