



**Our Mission: *Build healthy communities through generations***



## **Chiropractic Schedule of Fees**

### **Regular**

Consultation + Initial Assessment	\$80.00
Chiropractic Visit	\$40.00

### **Seniors/ Students**

Consultation + Initial Assessment	\$65.00
Chiropractic Visit	\$35.00

*Missed appointment without 24 hours' notice* \$20.00

## **Wellness Packages**

### **Regular**

12 visits for \$432 ( <i>\$48 savings</i> ) = \$36 per visit
24 visits for \$768 ( <i>\$192 savings</i> ) = \$32 per visit

### **Senior/Student**

12 visits for \$384 ( <i>\$36 savings</i> ) = \$32 per visit
24 visits for \$720 ( <i>\$120 savings</i> ) = \$30 per visit

\*\*\* All Wellness Packages are fully paid and booked in advance. \*\*\*

**We work as a team!**

**Physiotherapy:** Injury and rehabilitation.

**Chiropractic:** Brain, spinal health and prevention.

**Massage Therapy:** Muscle health and wellbeing.

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Gender: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_ May we contact you via e-mail? Y / N

Spouse/Partner: Y / N Children: Y / N #: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Location: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Do you want us to communicate with your doctor about your care? Y / N

**How did you hear about us?**  Existing patient \_\_\_\_\_  Online  Doctor  Other: \_\_\_\_\_

**HEALTHCARE HISTORY**

Have you ever seen?  Chiropractor  Physiotherapist  Massage Therapist  Naturopath

Date of last visit: \_\_\_\_\_

Have you ever had?  X-Ray  MRI  CT  Ultrasound

**HEALTH CHALLENGES**

What is the nature of your visit?

Wellness (help me to always be at the highest level of health)

Restorative (help me to restore my health)

Injury (help me to get out of pain)

Please explain your health challenges in order of importance to you:

1) \_\_\_\_\_

When did it begin? \_\_\_\_\_ Have you had this problem before? \_\_\_\_\_

This challenge started:  Suddenly  Gradually  Unknown

Have you noticed any other symptoms associated with this challenge? \_\_\_\_\_

What does this challenge stop you from doing? \_\_\_\_\_

Have you seen anyone about this challenge? \_\_\_\_\_

Prior treatments and results? \_\_\_\_\_

2) \_\_\_\_\_

When did it begin? \_\_\_\_\_ Have you had this problem before? \_\_\_\_\_

This challenge started:  Suddenly  Gradually  Unknown

Have you noticed any other symptoms associated with this challenge? \_\_\_\_\_

What does this challenge stop you from doing? \_\_\_\_\_

Have you seen anyone about this challenge? \_\_\_\_\_

Prior treatments and results? \_\_\_\_\_

3) \_\_\_\_\_

When did it begin? \_\_\_\_\_ Have you had this problem before? \_\_\_\_\_

This challenge started:  Suddenly  Gradually  Unknown

Have you noticed any other symptoms associated with this challenge? \_\_\_\_\_

What does this challenge stop you from doing? \_\_\_\_\_

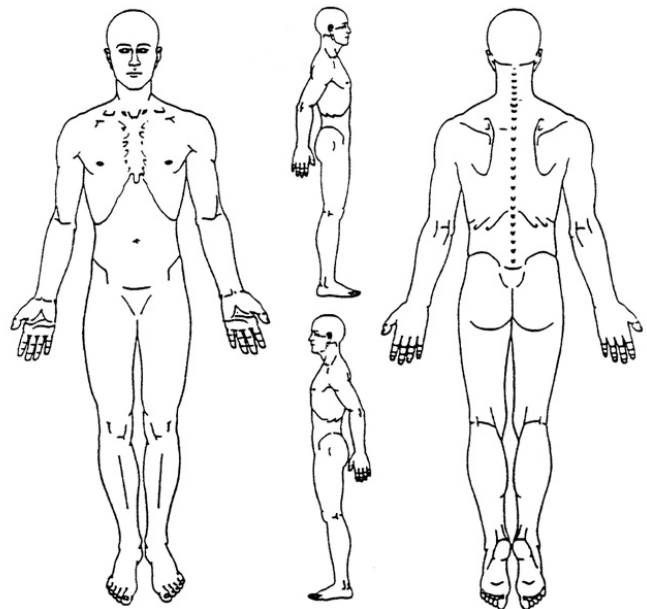
Have you seen anyone about this challenge? \_\_\_\_\_

Prior treatments and results? \_\_\_\_\_

**Please Draw Your Area of Concern**

Use letters to indicate type and location of discomfort:

- A = Ache
- B = Burning
- S = Stabbing
- N = Numbness
- P = Pins & Needles



**HEALTH INFORMATION**

Past injuries (birth complication, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, reactions to medication, environmental toxins):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any health conditions treated for in the past year:

\_\_\_\_\_

Please list any hospitalizations including year:

\_\_\_\_\_  
\_\_\_\_\_

**Medication and Supplements**

Please list any *medications* you are taking:

*Purpose and dose:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any *supplements* you are taking:

*Purpose and dose:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Gynecology and Pregnancy**

Age of first period: \_\_\_\_\_ Any chance you may be pregnant? Y  N  If so, # of weeks \_\_\_\_\_

First day of your last period? \_\_\_\_\_ How long does your period last? \_\_\_\_\_

How long is your cycle (first day of menses to last day before they start again)? \_\_\_\_\_

Are your menses? Irregular  Painful  Heavy

Do you experience hot flashes? Y  N

Date of last PAP : \_\_\_\_\_ Normal cells  Abnormal cells

Are you using any method of birth control? If yes, what type? \_\_\_\_\_

How long have you been using this method? \_\_\_\_\_

Do you experience any changes with your body or emotions prior to your menses/period or at any specific point in your cycle? \_\_\_\_\_

Have you ever been pregnant? If yes;

# of live pregnancies \_\_\_\_\_ # of miscarriage \_\_\_\_\_ # of abortions \_\_\_\_\_

## HEALTH CONDITIONS

Please check the following that apply to you:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Allergies _____      | <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> HIV                  | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Other Major Illness |   |

### General

- Loss of appetite
- Weight loss
- Weight gain
- Night sweats
- Nausea/vomiting
- Fevers
- Lumps
- Masses
- Dizziness
- Double vision
- Problems swallowing
- Problems talking
- Loss of consciousness
- Loss of balance

### Gastrointestinal

- Heartburn
- Constipation
- Diarrhea
- Bloating/Gas
- Laxative use
- Bad Breath
- Nausea/vomiting
- Abdominal cramps/pain
- Rectal Pain
- Hemorrhoids
- Blood in stool

### Respiratory

- Asthma
- Chronic Cough
- Shortness of breath
- Bronchitis
- Coughing Blood
- Pneumonia
- Pain w/breathing
- Mucous Production

### Learning Disability

- ADHD
- Dyslexia
- Memory loss
- Autism spectrum

### Neuropsychological

- Depression
- Disinterest
- Anxiety
- Schizophrenia
- Eating Disorder
- Concussion
- Fainting
- Dizziness
- Neuropathy
- Numbness
- Neurological condition (MS, ALS)

### Ear/Nose/Throat/Eyes

- Vision loss/blurring/pain
- Hearing loss/ringing
- Sinus infections/problems
- Ear infections
- Nose Bleeds
- Problems with teeth
- Night Blindness
- Sores on lips, tongue or m
- Facial Pain
- Recurrent sore throat

### Genitourinary

- Increased frequency
- Painful urination
- Blood in urine
- Discharge
- Kidney Stones
- Bladder/Yeast Infections
- Genital Sores
- Unable to hold urine
- Decrease in flow
- Urgency to void
- Wake at night to void

### Cardiovascular

- Chest pain
- Stroke
- High blood pressure
- Low blood pressure
- Poor circulation
- Pacemaker
- Heart Attack
- Irregular Heartbeat
- Swelling hands/feet
- Varicose Veins
- Blood Clots
- Impotence

### Adrenal

- Mental fog
- Poor focus
- Quick to react
- Low energy
- Fatigue
- Headache
- Chest tightness
- Restless legs
- Susceptible to stress

### Doctor Section

- Vascular
- Metabolic
- Aneurism
- Neoplasm
- Infection
- Congenital
- Trauma

## LIFESTYLE

What is the biggest stressor in your life?  Family  Work  Social  Financial  Health  Time

What do you love to do in your spare time (hobbies)? \_\_\_\_\_

How often do you exercise?  Daily  3-5 days/week  1-2 days/week  Infrequently

Smoke? Y / N # Packs/week \_\_\_\_\_ Drink alcohol? Y / N # Drinks/week \_\_\_\_\_

Recreational Drug use: \_\_\_\_\_

Hours of sleep? \_\_\_\_\_ Feel rested? \_\_\_\_\_

How often do you get cold/respiratory illness per year? \_\_\_\_\_

1            2            3            4            5

Where is your current level of health? (circle)    Very low    Poor    OK    Good    Excellent

If you had excellent health, what would you love to be able to do? \_\_\_\_\_

## FAMILY PROFILE

At HealthTweak we are here to help you and family live healthy and happy. Please mention below any health conditions or concerns they may have:

Children: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_

Other family members: \_\_\_\_\_

## PERSONAL HEALTH INFORMATION CONSENT FORM

I understand that HealthTweak is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. HealthTweak is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, HealthTweak will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that HealthTweak will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.

A termination of doctor-patient relationship may occur under following circumstances: 1. doctor can't provide effective treatment, 2. patient does not pay for care, 3. patient is physically or verbally abusive the doctor.

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

Name of Witness: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**Thank you for completing this form.**  
**If you would like us to *direct bill* your insurance, please provide your insurance information to our receptionist.**

## CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

### **Benefits**

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

### **Risks**

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- ♦ **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- ♦ **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- ♦ **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- ♦ **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- ♦ **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- ♦ **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

**HealthTweak is a multidisciplinary clinic; therefore other practitioners may have access to your file. If this poses any concern please let us know.**

**Alternatives**

Alternatives to chiropractic treatment may include consulting with other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor’s attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care.  
Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature of Patient (or legal guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Chiropractor

\_\_\_\_\_  
Date



<b>Date:</b> _____		Pain = 0; <1/3 ROM = 1; <2/3 ROM = 2; >2/3 ROM = 3 // Negative orthopedic test = 3; positive test = 0 Pain = 0; severe tightness/can't hold muscle = 1; tightness or 4/5 muscle test = 2; loose or 5/5 muscle test = 3																																																																																																																																																																																												
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