

Heartland Chiropractic

586 Centennial St. Winkler, Manitoba Ph. 331-3685

WELCOME TO OUR OFFICE

Prepared for: _____

To ensure your visit is a pleasant one, here are the procedures you can expect during the next 60 minutes.

Paperwork Complete this brief questionnaire and your health history form to help us get to know you. We will use this information to help formulate recommendations for your care.

Consultation You will meet the Doctor. The Doctor will review your history and determine if yours is a Chiropractic case. You will be informed of the cost of all office procedures before they are performed.

Examination Standard physical, orthopedic, neurological and Chiropractic tests will be performed to determine the cause(s) of your subluxation(s).

Spinal Image Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathology and make your Chiropractic care more precise.

Correlation Before proper care can be rendered, the Doctor will study your examination findings. Later, you will view your x-rays, review your findings and receive specific care and recommendations from the Doctor.

CONFIDENTIAL PATIENT CASE HISTORY

GENERAL INFORMATION

Miss Mrs. Ms. Mr. How would you like to be addressed? _____

Name _____ Date _____

Address _____ City _____ Postal Code _____

Email _____ Date of Birth _____ Sex M F Age _____
D / M / Y

MHSC # (6 digit) _____ (9 digit) _____ MPIC/WCB # _____

Phone Home () _____ Work () _____ Ext. _____ Cell/Other () _____

Occupation/Profession _____ Employer _____

Marital Status Single Married Divorced Widowed Number of Children _____

Name(s) and Age(s) _____

Name of Medical Doctor _____ Phone # _____

What is the major complaint for which you are seeking Chiropractic care? _____

Referred by: _____

Thank you. Again, we look forward to a healthy relationship with you!

Office Use Only:

Fee/Category

Heartland Chiropractic

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.

Please read the above information and then initial the boxes below before signing at the bottom of the form. Signing without initialing the boxes makes the forms invalid.

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 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 consent to the adjustment of the spine, or any extremities and for examination of the area of complaint as a form of chiropractic treatment, in Heartland Chiropractic by Dr. Denise Vicari, D.C., or any other practitioner she chooses to have in her office.

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

Dated this _____ day of _____, 20_____.

Print Patient's Name

Signature of Patient/Guardian

Signature of Doctor