Merivale Chiropractic and
Massage Clinic
460 West Hunt Club Road
Ottawa, ON K2E 0B8
613-226-8142
www.merivalechiro.com

PATIENT INTRODUCTION

Personal History:

Mr.__ Mrs.__ Miss__ Ms.__ Dr.__

Name: ____
First Middle Last

Your Address: ____

City:_________________Prov:________ Postal Code:_______________________

Telephone: Home:______________ Bus:_______________ Cell:_______________

E-Mail: ____

☐ Check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

Should you be accepted for care, do you wish to have appointment reminders sent to the email address provided above? ☐ Yes ☐ No __________(please initial)

Birth Date: (DD-MM-YYYY) _____-_____-_____ Age:_____ Male:____ Female:____

Occupation: ____________________ Employer: ____________________

Marital Status:_________________ Spouse's Name:____________________

Previous Chiropractor: ______________________________ City: ________________

Last visit to the Chiropractor:____

Reason for leaving: ____

____

Present MD: ______________________________________ City: ________________

Referred to our Centre by: ____

☐ Would you or your workplace/common interest group benefit from a complimentary workshop on how to improve health and reduce injuries?

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MERIVALE CHIROPRACTIC CLINIC

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$150.00
Radiology	$0.00-$84.00 (subsidized by OHIP)
X-Ray Report	$30.00
Adjustment / Visit	$50.00
Modality / Traction	$25.00 (in addition to regular visit fee)
Concussion Screening	$65.00 (in addition to regular visit fee)
Year End Progress Exam	$70.00
Acupuncture with Adjustment	$25.00 (in addition to regular visit fee)
Acupuncture 15 minutes	$50.00
30 minutes	$60.00
45 minutes	$80.00
1 hour	$100.00
Motor Vehicle Accident FSCO Submission Fee	$45.00 (one-time fee - Annually)

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, will be included in your initial fee.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

Who is responsible for your bill:

You:____ Spouse:___ Auto Ins.:___ WSIB:___ Extended Health Ins.:_____

SIGNATURE: ____________________________ DATE: ____________________

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

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ADULT CONSULTATION HISTORY

Your Name: ____

Your Main Complaint: ____

Any other Complaints: ____

____

How long have you suffered with this problem? ________________________________

What have you tried to do to get rid of this problem that **DID NOT** work? ______________

____

____

Have you become discouraged about handling this problem? __________________________

When your problem is at its worst, how does it make you feel? _______________________

____

How does this problem interfere with the following areas of your life?

WORK: ____

FAMILY: ____

HOBBIES: ____

LIFE: ____

Does handling this problem cause stress for you? ______________________________

____

What do you do that makes this problem worse? ______________________________

____

How much older does this make you feel: ____________________________________

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____________

What gives you some temporary relief? ______________________________________

What is the pattern of this problem? Constant ____, Intermittent ____, Occasional ____ Cyclic ____

What is the effect it has on your body functions? ______________________________

How did it start? ____

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Are you on any type of medication?___________, Please list all: ____________________________________

____

Could your problem have been caused by an injury at work?_______________________________

If yes, please give us the details: ____

____

Have you been involved in an auto accident? ____

Date of accident: ____

Any difficulties from this?____

____

Tell us about your birth by checking ALL that apply:

- ☐ Born at home
- ☐ Born in hospital
- ☐ Born at birthing centre
- ☐ Via C-section
- ☐ Use of forceps
- ☐ Breach position
- ☐ Other: ___________________________
____
____

Do you have any children? ______________________Number of children:___________________________

Children's Names:____

Do they have any health problems that you are aware of? ___________________________________

____

Is there any other information you would like us to know?_____________________________________

____

____

____

SIGNATURE: _____________________________________ DATE: _________________________________

For Women Only

Date of your last menstrual period: ______________________Do you suffer from PMS? _______________

Are using any means of contraception? ____

Do you experience severe cramping with your menstrual period? _______________________________

<u>Thank You!</u>

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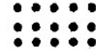
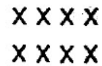
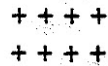
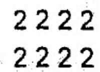
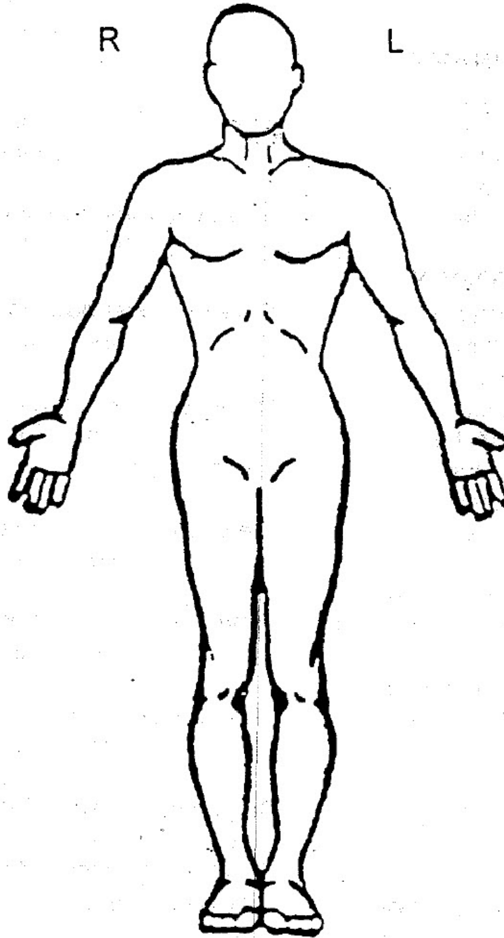
MCC SYMPTOM DIAGRAM

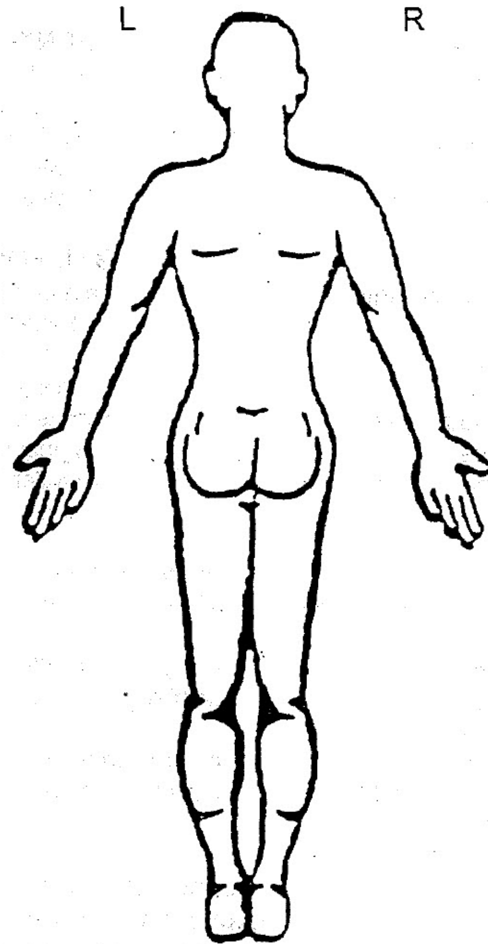
Patient Name: ______ **File #:** ______ **Date:** ______

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

Symbols:

Numbness		Pins & Needles	
Burning		Stabbing & Sharp	
Dull & Aching		Stiff & Tight	





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HEALTH STATUS SURVEY

Patient Name: ______________________ **File #:** ______________ **Date:** __________

Please circle (**O**) any conditions or symptoms presently causing you problems.
Please check (√) those conditions or symptoms, which have been a problem to you in the past.

GENERAL SYMPTOMS

- ❑ Loss of consciousness
- ❑ Blackouts
- ❑ Headache
- ❑ Fever
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Clumsiness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Numbness or tingling
- ❑ Pain
- ❑ Nervousness
- ❑ Loss of weight

MUSCLES & JOINTS

- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Shoulder pain
- ❑ Arm/Forearm pain
- ❑ Elbow pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Arthritis
- ❑ Weakness or loss of strength

E.E.N.T.

- ❑ Blurred vision
- ❑ Failing vision (one/both eyes)
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Eye pain
- ❑ Deafness, Earache
- ❑ Ringing, buzzing, any noise in the ears
- ❑ Asthma
- ❑ Frequent colds
- ❑ Sinus infection
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Slurred or other speech problems
- ❑ Difficulty swallowing

RESPIRATORY

- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficulty breathing

CARDIOVASCULAR

- ❑ Bleeding Disorder
- ❑ High blood pressure
- ❑ Pain over heart
- ❑ Stroke
- ❑ Hardening of arteries
- ❑ Varicose veins
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Heart or blood disease
- ❑ Angina

GENTOURINARY

- ❑ Trouble urinating
- ❑ Blood in urine
- ❑ Kidney infection
- ❑ Bed-wetting
- ❑ Prostate trouble

G.U. FOR WOMEN

- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Vaginal, discharge
- ❑ Swollen breasts
- ❑ Lumps in breasts

Have you ever been on birth control pills? Yes ❑ No ❑

Are you currently taking the birth control pill? Yes ❑ No ❑

# of pregnancies ______________
# of children__________________

Please inform the doctor if you have ever tested POSITIVE for HIV or Hepatitis A/B/C.

SKIN

- ❑ Rashes, itching
- ❑ Bruise easily
- ❑ Dryness
- ❑ Boils
- ❑ Hives (allergy)

GASTROINTESTINAL

- ❑ Poor appetite
- ❑ Indigestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting (blood?)
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Gall bladder trouble
- ❑ Intestinal worms
- ❑ Ulcer
- ❑ Diabetes

Have you ever had any fractures? Yes ❑ No ❑

Have you ever been in a car accident? Yes ❑ No ❑

Have you ever been hospitalized? Yes ❑ No ❑

If yes, why?________________

Are you currently a smoker? Yes ❑ No ❑

Have you ever smoked in the past? Yes ❑ No ❑

Have you ever been diagnosed with cancer? Yes ❑ No ❑

Do you take medication on a regular basis? Yes ❑ No ❑

If so, what? (blood thinner, blood pressure, etc.)_______

____