

# ANDERS VICTORIA FAMILY CHIROPRACTIC

## PERSONAL INFORMATION

Title: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Dr.		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date:	
First Name		Initial	Last Name		Alberta Health Care #:
Street Address:		City:	Province:	Postal Code:	Email (optional):
Home Phone Number:		Cell Phone Number:		Emergency Contact Name and Phone Number	
Birthday (Month/Day/Year)		Spouse's Name		# of Children	Occupation: Is this a Work Related Injury?

How did you hear about us?  Yellow Pages  Website  Facebook  Referred By:

## MEDICAL AND CHIROPRACTIC INFORMATION

Name of Medical Doctor		Last Visit	City	List Allergies:
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What is Your Reason for Seeking Chiropractic Today?

How Long Have You Been Experiencing This?	Have You Received Previous Treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes:	What Was the Treatment?
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Have You Had Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete the following)</i>	Name of Previous Chiropractor	Last Visit
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Reason For Seeking Care:	Results <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
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## MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

**Please check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Weight gain                   |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Weight loss                   |
| <input type="checkbox"/> Weakness in arms     | <input type="checkbox"/> High blood pressure           |
| <input type="checkbox"/> Weakness in legs     | <input type="checkbox"/> Elevated cholesterol          |
| <input type="checkbox"/> Numbness in arms     | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Numbness in legs     | <input type="checkbox"/> Cancer                        |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Arthritis                     |
| <input type="checkbox"/> Neck pain            | <input type="checkbox"/> Heartburn                     |
| <input type="checkbox"/> Upper back pain      | <input type="checkbox"/> Loss of sleep                 |
| <input type="checkbox"/> Low back pain        | <input type="checkbox"/> Vision loss/changes           |
| <input type="checkbox"/> Arm pain             | <input type="checkbox"/> Difficulty breathing          |
| <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Constipation         | <input type="checkbox"/> Nausea                        |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Poor control of bowel/bladder |
| <input type="checkbox"/> Swelling of joints   | <input type="checkbox"/> Frequent urination            |
| <input type="checkbox"/> Poor concentration   | <input type="checkbox"/> Depression                    |
| <input type="checkbox"/> Hearing loss/Ringing | <input type="checkbox"/> Auto-Immune Disease           |
| <input type="checkbox"/> Other: _____         |  |

**Family History:**

- Cancer
- Stroke
- Diabetes
- Hypertension
- Other: \_\_\_\_\_

**Social History**

- Smoke
- Alcohol
- Caffeine
- Current Exercise Level

Please list all the **surgeries** you have had in the past:

\_\_\_\_\_

\_\_\_\_\_

Please list all the **medications and vitamins/supplements** you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

**For Women Only:**

- Are you Pregnant?  Yes  No Due Date: \_\_\_\_\_
- Menstrual pain  Mood disturbance
  - Irregular cycle  Menopause
  - Hot flashes

What type of care interests you?

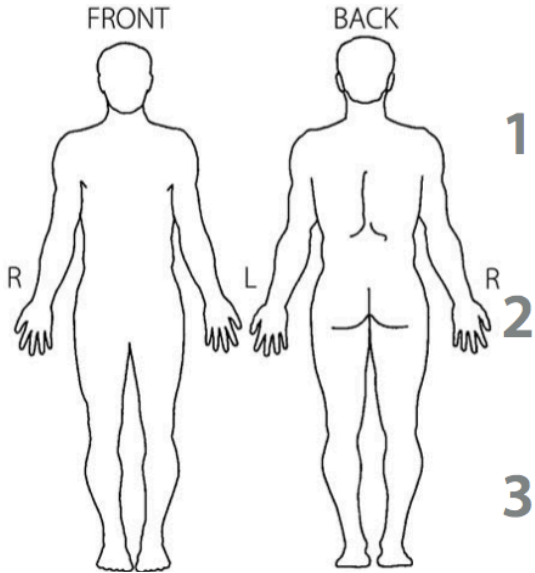
- Pain relief
- Regular Chiropractic and Wellness care to prevent injury, sickness, and disease and to live to my full potential

Please Turn Over

Name:

Date:

## CHIEF COMPLAINT



### HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

Ache XXXX	Burning ++++++	Numbness ^ ^ ^ ^ ^ ^	Tingling *****	Stabbing/Sharp ////////	Deep =====
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How did your symptoms start?

- sudden
- gradual
- car accident
- work related injury

When did your symptoms start?

- 0-3 months ago
- 3-6 months ago
- 6-9 months ago
- 1 year or more ago

Please mark on the line below the level of your discomfort.

0 \_\_\_\_\_ 10  
no pain \_\_\_\_\_ worst pain

## OFFICE POLICY AND FEE SCHEDULE

Welcome to our clinic! We want our office environment to be as positive and constructive as possible, to maximize the healing potential for our patients. Here are a few guidelines and some information to ensure your visits to the office run smoothly.

- Please help us keep our clinic clean by removing wet or muddy footwear when you enter the office.

### Scheduling

- We encourage all appointments to be scheduled before hand to reduce patient waiting time.
- Drop-ins are welcomed, but scheduled patients will be seen first.
- Cancellation notice** - We value your time and expect that you likewise respect the doctor's time by making every effort to notify us in the event that you have to miss an appointment. We understand that unforeseen events may make it difficult for you to make your appointment, but we appreciate advanced notice if you need to reschedule your treatment. Repeated violations of this request may result in a charge for the full amount of the missed treatment.

### Payment

- Payment is expected in full for each visit. We accept Cash, Cheque, Debit, Visa, Master Card
- Direct Billing is available for Alberta Blue Cross, ASEBP, Great West Life, Sun Life Financial, Green Shield
- Should you discontinue treatment, any outstanding balance will become due immediately and payable in full by you

### Fees

#### Adult Patients

Initial Consultation \$90.00  
Adjustments \$45.00

#### Child Patients

Initial Consultation (Under 18) \$70  
Adjustments (13 and older) \$35  
Adjustments (0-12) \$30

#### Other Services

Custom Orthotics \$350  
After hours/Emergency - \$55  
Supplements – as seen

### Current Promotions:

- The last Thursday of every month is Senior's Day. All patients that are 65 years of age and older can get treated for \$30
- The first week of every month is Family Week. If the whole family attends, everyone will receive treatment for \$35 each

**Referrals** – Our practice grows through referrals from satisfied patients. We encourage and appreciate when patients are so happy with their treatments that they bring in their friends and family!

With this signature, I declare that I have read and understand the terms and conditions of Anders Victoria Family Chiropractic.

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

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

\_\_\_\_\_  
(Signature of Patient or Parent/Legal Guardian)