Welcome To Our Office!

Outline of procedures for potential practice members:

STEP 1:

All new patients are requested to thoroughly complete a confidential "Health History + Lifestyle Record"

STEP 2:

Your first consultation with the staff and doctor to discuss your concerns and interests.

STEP 3:

You will receive a Comprehensive Examination to determine if chiropractic care is appropriate for you. This is an in-depth, advanced assessment of your nervous system to determine how well your brain is communicating with your body. Any interference to this communication may be measured by the following tests: spinal function, Range of Motion, Postural Assessment, Muscle Testing, Advanced Nerve Testing, Bilateral Weight Scales and Balance. As well, if indicated, x-rays will be ordered to visualize the location of spinal damage or problems.

STEP 4:

You will be advised as to a time you can return for your "Doctor's Report" when they will inform you as to your examination results and whether or not your case has been accepted. If accepted, your recommended adjustment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

STEP 5:

Chiropractic care will begin after your "Doctor's Report" and continue as scheduled until your state has been fully corrected, or until maximum possible improvement has been obtained.

To save time and allow us to better serve you, please complete all questions on the following pages.

Thank you!

Dr. Joshua Gelber, D.C.
Principled Wellness Chiropractor

Annex Family CHIROPRACTIC
EMPOWERING YOU FOR OPTIMAL HEALTH

416 967 4466 • annexfamilychiropractic.com
206-738 Spadina Ave, Toronto, ON M5S 2J8

Patient Information

Last Name: _____ Given Name: _____

Birthdate (D/M/Y): _____ Gender: ☐ F ☐ M Marital Status: ☐ S ☐ M ☐ D ☐ Common-Law

Address: _____ Apt. No. _____

City: _____ Province: _____ Postal Code: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

E-mail: _____

☐ Yes, I consent to receiving electronic newsletters, announcements and appointment reminders at this email address. Disclaimer: Annex Family Chiropractic is the only party using this email address for the purposes of communicating with you for appointments, statements and invoices, calendars, and monthly newsletters. This email address will not be sold, shared, or entered in unsecure databases.

Occupation, Employer's Name, Work Address (Describe general work duties, I.E.: sitting, standing, physical labour, repetitive motions, driving, etc.)

_____

Medical Doctor Name, Address, Telephone # (if you currently have one)

_____

Who may we thank for referring you to Annex Family Chiropractic?

_____

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Health Profile

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us profiles of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

CHILDHOOD (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Y	N
Did you have any childhood illnesses?	☐	☐
Did you have any falls?	☐	☐
Did you fall/jump from a height over three feet? (eg. crib, bunk bed, trees)	☐	☐
Were you involved in any car accidents as a child?	☐	☐
Did you take / use any drugs?	☐	☐
Did you have any surgery?	☐	☐

	Y	N
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐
Did you play youth sports?	☐	☐
Did you suffer any other traumas? (Physical or Emotional)	☐	☐
Were you vaccinated?	☐	☐
As a child, were you under any chiropractic care?	☐	☐

ADULT (18 TO PRESENT)

	Y	N
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐
Do / did you participate in extreme sports?	☐	☐
Do / did you play any adult sports?	☐	☐

Describe your stress level: (1 = none / 10 = extreme)
Occupational: _____ Personal: _____

On a scale of Poor (P), Good (G), Excellent (E)
describe your: Diet: _____ Sleep: _____ Health: _____

Do you have a regular exercise program? ☐ Y ☐ N

If yes, how often to do exercise?

- ☐ 1-2 times per week
- ☐ 2-4 times per week
- ☐ 4+ times per week

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Health Profile

CURRENT HEALTH

☐ I am here for a preventative health assessment (skip to "Please check")
OR
Main/Current Health Concern(s): _____

When did this begin? _____ Has it occurred before? ☐ Y ☐ N

Since the problem started, it is… ☐ About the same ☐ Getting Better ☐ Getting Worse

If you are experiencing pain, is it…
☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles / Numb ☐ Constant ☐ Intermittent ☐ Burning

Place an X on the scale to indicate the severity of your discomfort (if applicable):

Least 1 2 3 4 5 6 7 8 9 10 *Worst*

What makes it worse?
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down ☐ Cold ☐ Dampness
☐ Other: _____

What makes it better?
☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Chiropractic ☐ Supplements
☐ Other _____

It interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Health Professionals seen for this problem:

☐ Chiropractor _____
☐ Medical Doctor _____
☐ Other _____

Please check (☐) all symptoms you have ever had, even if they don't seem related to your current problem and (x) on those that are current symptoms.

NERVOUS SYSTEM

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Convulsions
- ☐ Fainting
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/ Clicking Jaw
- ☐ General Stiffness

GASTRO-INTESTINAL

- ☐ Black/Bloody Stool
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Colitis
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after meals

C-V-R

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Varicose Veins
- ☐ Lung Problems/ Congestion
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

INTAKE

- ☐ Coffee
- ☐ Alcohol
- ☐ White Sugar
- ☐ Tea
- ☐ Cigarettes

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Health Profile

SLEEPING POSITION

☐ Back ☐ Side ☐ Stomach

Type of Mattress: _____
Age of Mattress: _____
Is it comfortable? ☐ Y ☐ N
Type of Pillow: _____
Age of Pillow: _____

MALE/FEMALE

☐ Menstrual Irregularity
☐ Menstrual Cramping
☐ Vaginal Pain
☐ Infections
☐ Breast Pain/Lumps
☐ Prostate/Sexual Dysfunction

FEMALE

When was your last period? _____
Are you pregnant? ☐ Y ☐ N ☐ Unsure

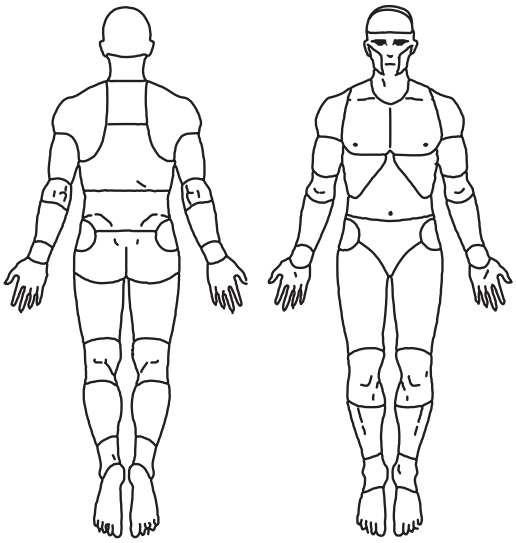
GENERAL

☐ Fatigue
☐ Loss of Sleep
☐ Fever
☐ Headaches
☐ Allergies

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Mental Disorder
☐ Heart Disease
☐ Psoriasis
☐ Influenza
☐ Arthritis
☐ Epilepsy
☐ Measles
☐ Thyroid
☐ Eczema

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF YOUR DISCOMFORT AND ANY RADIATION OF PAIN.



Current Medications: _____

Current vitamins or supplements: _____

Do you currently wear custom orthotics/shoe inserts? _____

Have you had x-rays taken in the last six months? ☐ Y ☐ N
If Yes, at what facility? Of what? _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Spouse _____

Children _____

Number of Children: _____ Names & Ages: _____

Mother/Father _____

Brother/Sister _____

Other _____

Has anyone in your family ever had a spinal check-up? ☐ Y ☐ N
If Yes, at what facility? _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to improve your health: _____

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Why Chiropractic Care?

People go to a chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Preventative Care). These are the three types/phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three types/phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Preventative Care – Life Enhancement and Wellness Care
☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
☐ Relief Care – Band-Aid Care only
☐ *Check here if you want the doctor to select the type of care appropriate for your condition.*

PLEASE READ CAREFULLY:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

In order for the Doctor at Annex Family Chiropractic to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiograph examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by him or her or any party authorized to do so by them.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Annex Family Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Our only practice objective is to eliminate a major interference to the expression of the body's internal power. Our method is specific adjusting to correct vertebral subluxations.

I, _____ have read and understand the subluxation pamphlet (provided to you at your initial appointment) .

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept the potential for chiropractic care on this basis.

_____ _____

Patient Signature/Guardian's Consent Date

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