Goldsworthy
chiropractic & wellness centre

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Today's Date: _____

Preferred Name: _____ Preferred Pronouns:_____

Current Gender Identity: _____Gender Assigned at Birth: _____

Date of Birth: Day _____Month_____ Year_____

Address: _____Apt.# _____

City:_____Postal Code: _____

Home Phone: _____Cell Phone: _____Work Phone:_____

E-mail:_____

Occupation: _____ Employer Name: _____

Extended Health Insurance? Yes _____No _____

Insurance Company: _____

Family Physician: _____ Phone:_____

Family Physician Address: _____

Primary Relationship (please describe your current relationship status):

_____

How did you find out about this service?

Google_____ Yellow Pages _____Signage _____ If other please specify _____

Referred by: _____ Relationship: _____

Previous Chiropractic Care? No _____Yes _____If yes, when: _____

Recent Surgical Operations: _____

List of Medications :_____

Reason for Visit: _____

Dr. Adrienne Goldsworthy
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo ON N2J 4R9
Phone 519-886-4814

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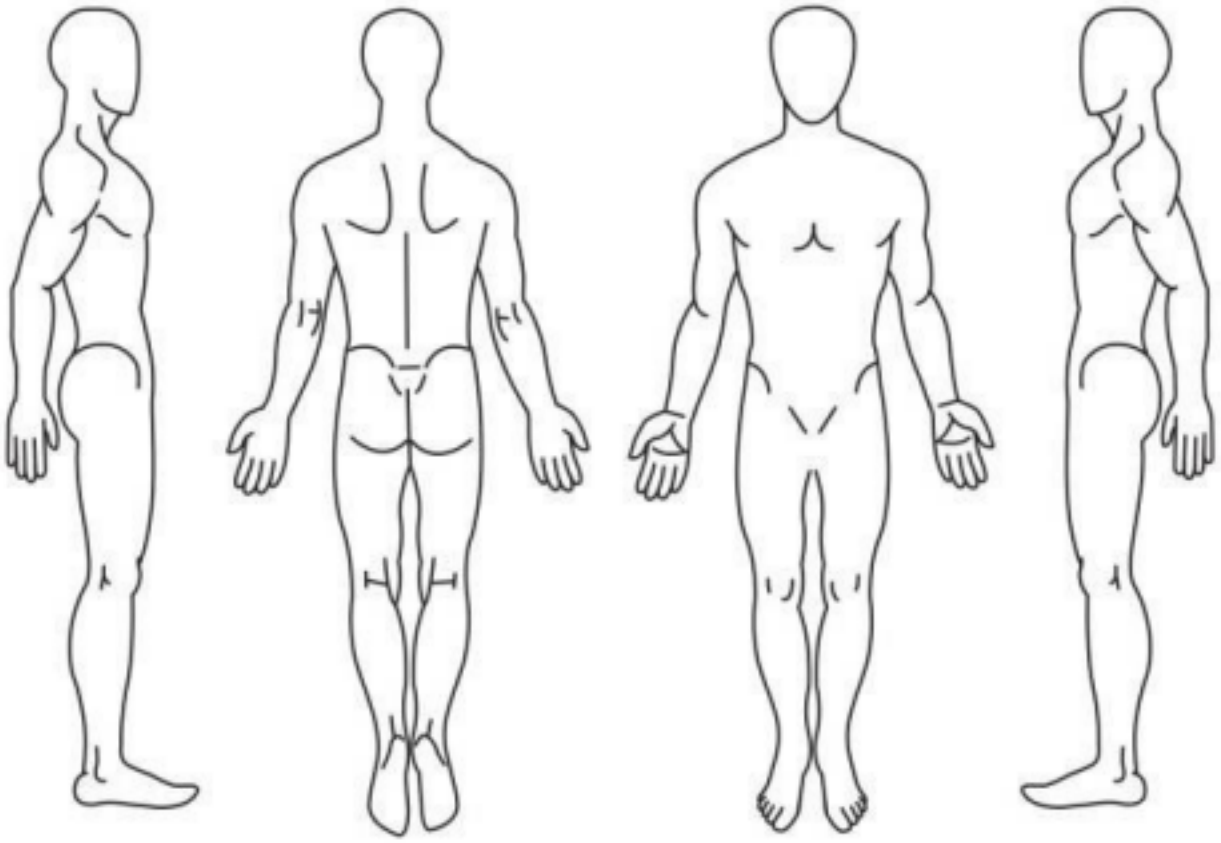
Name: _____ Date: _____

SYMPTOMS DIAGRAM

In the diagram below, please mark the area(s) on the body which you feel best represent your pain(s) or sensation(s) you are experiencing. Using the symbols below please indicate all areas.

Numbness ====	Dull & Achey ####	Stabbing & Sharp ~~~~
Burning xxxx	Pins & Needles oooo	Stiff & Tight 2222



Right Side Back Front Left Side

If multiple areas are selected, please indicate your PRIMARY complaint (the area which you are most concerned about).

_____

_____

MEDICAL HISTORY

Date of last family doctor visit _____

Have you ever been diagnosed with any of the following?

- ☐ Cancer
- ☐ Heart Disease
- ☐ Lung Cancer
- ☐ Mental Health Issues
- ☐ Digestive conditions
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other_____

Has anyone in your immediate family been diagnosed with the following? Please list who.

- ☐ Cancer
- ☐ Heart Disease
- ☐ Lung Cancer
- ☐ Mental Health Issues
- ☐ Digestive conditions
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

PERSONAL LIFESTYLE AND HABITS

On average, how often do you exercise? _____

If so, what forms of exercise? _____

On average, how much water do you drink? _____

On average, how much alcohol do you drink? _____

If applicable, what activities are involved in your occupation? (Sitting at a computer, standing, heavy lifting, etc.)

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SYSTEMS REVIEW

Please X the box for any conditions or symptoms **presently** causing you problems. Please circle (O) the box for those conditions or symptoms **that you have had in the past**.

GENERAL SYMPTOMS

- ☐ Headache
- ☐ Fever
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Loss of Weight
- ☐ Loss of Consciousness
- ☐ Vision Blackouts
- ☐ Headache
- ☐ Excess Sweating
- ☐ Night Sweats
- ☐ Night Pain
- ☐ Generalized Pain

NEUROLOGICAL

- ☐ Dizziness
- ☐ Fainting
- ☐ Problem Speaking
- ☐ Problem Swallowing
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Nausea
- ☐ Clumsiness
- ☐ Numbness or Tingling

MUSCLES & JOINTS

- ☐ Stiff/Sore Neck
- ☐ Mid Back Ache
- ☐ Low Back Ache
- ☐ Swollen Joints
- ☐ Painful Tailbone
- ☐ Ankle/Foot Trouble
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Arthritis
- ☐ Arm/Forearm Pain
- ☐ Loss of Strength

Eyes/Ears/Nose/Throat

- ☐ Failing Vision
- ☐ Crossed Eyes
- ☐ Eye Pain
- ☐ Deafness
- ☐ Earache
- ☐ Ring/Buzz in Ears
- ☐ Frequent Colds
- ☐ SInus Infection
- ☐ Enlarged Glands
- ☐ Enlarged Thyroid

SKIN

- ☐ Rashes/Itching
- ☐ Bruises Easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives (Allergies)

RESPIRATORY

- ☐ Chronic Cough
- ☐ Spitting up Phlegm
- ☐ Spitting up Blood
- ☐ Chest Pain
- ☐ Difficult Breathing
- ☐ Asthma

CARDIOVASCULAR

- ☐ Rapid Heart Beat
- ☐ High Blood Pressure
- ☐ Pain Over Heart
- ☐ Stroke
- ☐ Hardening of Arteries
- ☐ Varicose Veins
- ☐ Swelling of Ankles
- ☐ Poor Circulation
- ☐ Angina
- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Heart/Blood Disease

GENITOURINARY

- ☐ Troubles Urinating
- ☐ Blood in Urine
- ☐ Kidney Infection

Currently on Birth Control Pills/Patch?

- ☐ Yes
- ☐ No

Previously on Birth Control Pills/Patch?

- ☐ Yes
- ☐ No

Number of Pregnancies: ___
Number of Children: ___

G.U. FOR WOMEN

- ☐ Painful
- ☐ Menstruation
- ☐ Excessive Flow
- ☐ Hot Flashes
- ☐ Irregular/Absent Cycle
- ☐ Cramps or Backache
- ☐ Vaginal Discharge
- ☐ Swollen Breasts
- ☐ Lump in Breasts
- ☐ Menopausal Symptoms

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Indigestion
- ☐ Excessive Hunger
- ☐ Belching or Gas
- ☐ Nausea
- ☐ Vomiting (blood?)
- ☐ Pain Over Stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gallbladder
- ☐ Intestinal Worms
- ☐ Ulcer
- ☐ Diabetes

Have you ever had any fractures/breaks?

- ☐ Yes
- ☐ No

If Yes-where?

Have you ever been in a car accident?

- ☐ Yes
- ☐ No

If yes- when?

Have you ever been hospitalized?

- ☐ Yes
- ☐ No

Why?When?

Are you currently a smoker?

- ☐ Yes
- ☐ No

How much _____

Did you smoke previously?

- ☐ Yes
- ☐ No

How much _____

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PATIENT PRIVACY CONSENT FORM

Privacy of your personal information is an important part of our office providing you with quality chiropractic care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Dr. Jeff Goldsworthy acts as the Privacy Information Officer.

All staff members who have access to your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

*only necessary information is collected about you
*we only share your information with your consent
*storage, retention and destruction of your personal information complies with existing legislation and privacy protocols *our privacy protocols comply with legislation, standards of our regulatory bodies and the law

Do not hesitate to discuss our policies with Dr. Jeff or any member of our staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality Health Care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is disclosing your information.

This office will collect, use, and disclose information about you for the following purposes:
*to deliver safe and efficient patient care
*to identify and to ensure continuous high quality service
*to assess your health needs
*to provide health care
*to advise you of treatment options
*to enable us to contact you
*to establish and maintain communication with you
*to offer and provide treatment, care and services
*to communicate with other treating health care providers, including but not limited to specialists, referring doctors, family doctors, massage therapists, naturopaths
*to allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
* to allow us to efficiently follow-up for treatment, care and billing
*for teaching and demonstrating purposes on an anonymous basis
*to complete and submit claims for third party adjudication and payment
*to comply with legal and regulatory requirements, including the delivery of patient's charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act

*to comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patient's charts and records in a timely fashion for regulatory and monitoring purposes *to permit potential purchasers, practice brokers or advisors to evaluate the practice
*to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
*to deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damage, if any
*to prepare materials for the Health Professions Appeal and Review Board (HPARB)
*to invoice for goods and services
*to process credit card payments
*to collect unpaid accounts
*to assist this office to comply with all regulatory requirements
*to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any condition supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Goldsworthy Chiropractic and Wellness Centre can collect, use, and disclose personal information about: (Patient's name) _____ as set out above in the information about the office's privacy policies.

Signature _____

Print Name _____
(Print name and relationship to patient if signing for a child under 16)

Date _____ Signature of Witness _____

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FEES SCHEDULE

OHIP no longer covers your chiropractic care. Employer benefit plans may cover all or part of your chiropractic care. It is your responsibility to check with your benefits provider plan.

Service	Fee
Chiropractic Initial Exam and Treatment	$95 (Adult) $90 (Student/Senior) $55 (16 years and under) $50 (5 years and under)
Chiropractic Subsequent Visit	$51 (Adult) $44 (Student/Senior) $36 (16 years and under) $36 (5 years and under)
Re-evaluation	$55
Shockwave	$85 – full shockwave with laser $55 – shockwave with laser (< 5 points) $25 – shockwave no laser
Modality with Chiropractic care - Laser block - Laser point - Ultrasound - Interferential current therapy	$5 - for first modality per visit +$3 for second modality per visit +$2 for third modality per visit Note: Laser is always $5, both point and block treatment together $10
X-Ray Report Reading	$15
Back Power Test	$15
Missed Appointment (2nd miss)	Full fee as above
Weekend or Home Visits	$63

DR. ADRIENNE'S HOURS

M 12-6pm | T 8am-1pm, 3-7pm | Th 8am-1pm, 3-7pm | F 8am-2pm

☐ I have read and understood the fees

_____ _____

Signature Date

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MISSED APPOINTMENT AND LATE CANCELLATION FEE POLICY

We're glad you have chosen us to provide you with your health care. Your practitioner books your appointments to keep you in top shape. When you miss or cancel your appointment you affect your health and those of clients that could have used that time.

Our Centre requires 48 business hours' advanced notice in the event you need to reschedule or cancel an appointment. Appointments on Monday must be canceled before the scheduled appointment time on the previous Thursday.

Full treatment price will be charged for appointments missed, canceled, or rescheduled with less than 48 hours' notice.

Please be aware that in some cases repeat missed appointments can lead to termination of services. None of these fees are insurance reimbursable.

I _____, have read the above information that explains the missed appointment, late cancellation, and rescheduling fee policy. I understand that at least 48 business hours' notice is required to avoid these charges.

Signature: _____ Date: _____

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