# WELCOME TO THE OFFICE

## ABOUT THE DOCTOR

Dr Jeff was born in Kitchener and attended secondary school at both Waterloo Collegiate Institute and Grand River Collegiate. Dr. Jeff went on to attend the University of Waterloo where he graduated with honours Bachelor of Science degree in Kinesiology, in 1983. He attended the Canadian Memorial Chiropractic College in Toronto and graduated in 1987.

Dr Jeff has taken numerous sport injury courses at the University of Waterloo and the Chiropractic College. Jeff is also an avid sportsman. He was selected as a member of the Canadian Badminton team from 1979-1983. He was the 1994 Canadian Master champion and the 1997 and 1999 United States Open Masters champion.

## ABOUT THE OFFICE

Your back…

Your spine is the foundation of your body. It performs three major functions:

1. It allows you to move whatever direction you so desire.
2. It protects your spinal cord.
3. It keeps you upright.

Your spine is constantly subjected to minor traumas and irritations from your work, posture, and lifestyles. Therefore, your spine should be examined on a regular basis to prevent back-related disorders.

Your initial appointment includes a thorough consultation, examination, and radiographs (x rays) if required.

It is the intention of the personnel of our office to provide for your optimum health as thoroughly and efficiently as possible. We therefore wish to acquaint you with our customary office procedures.

Dr Jeff provides chiropractic health care, incorporating rehabilitation/physiotherapy, risk management and education.

Our aim is to provide quality, affordable and natural health care that respects traditional chiropractic techniques and philosophy, while remaining open to cutting edge research and development that expands the field of chiropractic.

Our policy is to serve our patients to the best of our knowledge and to correct your spinal problems rather than just to relieve your pain temporarily. We wish to correct, strengthen, and rehabilitate your spine. To accomplish this, we need your complete co-operation in the following ways:

1. Follow Dr Jeff's directions and advice to improve recovery time and adhere to exercise protocols that maintain health.
2. Keep your allotted appointment schedule, for speedy recovery.

**A missed appointment hurts three people: Yourself, because your progress in achieving restored health is interrupted, your chiropractor and another patient who could have had your appointment.**

On your second missed appointment you will be charged in full. If you must reschedule an appointment, we appreciate at least forty-eight (48) hours' notice. There is an answering machine for the times we are out of the office. If you have any questions regarding the treatments, fees, or office policies, please discuss them with us promptly and frankly as to avoid any misunderstandings.

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

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

**NAME**:_____

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
- ☐ Bed Wetting
- ☐ Prostate Trouble

**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
- ☐ Gall Bladder
- ☐ 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 _____

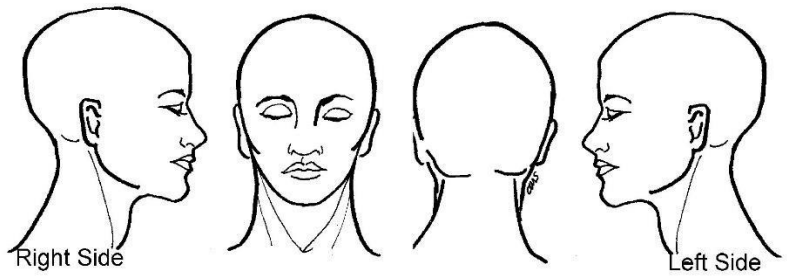
**Did you smoke previously?**
☐ Yes ☐ No
How much _____

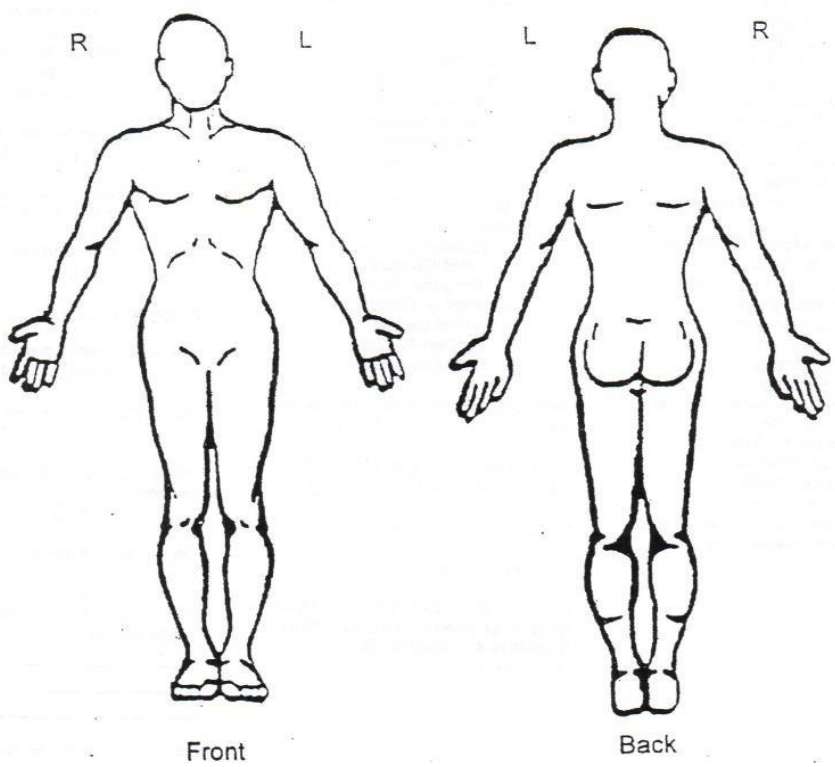
# Symptom Diagram

In the diagrams provided 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.

**Symbols:**

| | | | | | |
|---|---|---|---|---|---|
| Numbness | □□□□□ | Dull & Achy #### | | Stabbing & Sharp | ~~~~ |
| Burning | **××××** | Pins and Needles **oooo** | | Stiff & Tight | **2222** |




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

Goldsworthy
chiropractic & wellness centre

## 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 encounter 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:

Patients 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 _____

Dr. Jeff Goldsworthy
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo ON N2L 4R9
Phone: 519-886-4814

**Informed Consent to Chiropractic Treatment with Dr. Jeff Goldsworthy**

There are risks and possible risks associated with manual therapy techniques used by Doctor of Chiropractic. You should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains because 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 do 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 Doctor of Chiropractic.

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 the Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

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

Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature (Legal Guardian) Witness of Signature

Name: _____ Name: _____

(Please print) (Please print)

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

## FEES SCHEDULE

OHIP no longer covers your chiropractic care. Employer benefit plans may cover all or part of your chiropractic care. Check with your benefits provider plan.

| | |
|---|---|
| Consultation and Exam (Adult) | 82.00 |
| Subsequent Visit | 45.00 |
| Consultation and Exam (students and seniors) | 62.00 |
| Subsequent Visit | 40.00 |
| Consultation and Exam (6 yrs. to 16 yrs.) | 44.00 |
| Subsequent Visit | 30.00 |
| Consultation and Exam (5 yrs. and under) | 30.00 |
| Subsequent Visit | 25.00 |
| Consultation and Exam (Carpel Tunnel Patient) | 82.00 |
| Subsequent Visit | 49.00 |
| Ultrasound (US) (no treatment) | 5.00+10.00 Modality Fee 15.00 |
| Muscle Stimulator (no treatment) | 5.00+10.00 Modality Fee 15.00 |
| Laser (no treatment) | 10.00+10.00 Modality Fee 20.00 |
| Full Art (Active Release Therapy) with Adjustment | 47.00 |
| Full Shockwave treatment (includes full laser) | 80.00 |
| Re-evaluation | 5.00 |
| Back Power Test | 5.00 |
| Missed Appointments (2nd miss) | Full Fee as Above |
| Weekend or Home Visits | 63.00 |
| X-rays reading | 15.00 |

## ON THE JOB INJURIES

Worker's Compensation does cover chiropractic care. The decision to accept or reject a Worker's Compensation claim is the sole responsibility of the Worker's Compensation Board. Dr Jeff does accept Worker's Compensation cases, but the patient is responsible for the payment should the Workers Compensation Board reject the claim.

## DR. JEFF'S HOURS

| | |
|---|---|
| MONDAY | |
| TUESDAY | 8:00 am to 1:00 pm |
| WEDNESDAY | 2:15 pm to 6:45 pm |
| THURSDAY | 2:45 pm to 7:00 pm |
| FRIDAY | |

New patient visits and orthotic gait analysis times are Tuesdays at 1:00 pm Wednesdays at 6:00 pm and Thursdays at 2:15 pm.

Thanks for your co-operation. Dr. Jeff and Staff

_____ _____

(SIGNATURE) (DATE)

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

# IE Questions — Meet the Patient Where They Are!

Patient Name: _____ Date: _____

**First Time Chiropractic Patients**

1. What do you know about chiropractic care?
2. What are your expectations of coming to our clinic? E.g., the treatment plan, the results, what you will gain from the experience at Goldsworthy Wellness.
3. What concerns or fears do you have right now?
4. Do you have any special requests from us or anything else you would like to add about how you are feeling about this?

**Patients Who Have Been to Other Chiropractors in the Past**

1. What did you most like about your previous experience with chiropractic care?
2. What was your least favourite part of the experience?
3. What are your expectations of coming to our clinic? E.g., the treatment plan, the results, what you will gain from the experience at Goldsworthy Wellness.
4. What concerns or fears do you have right now?
5. Do you have any special requests from us or anything else you would like to add about how you are feeling about this?

| Patient Responses |
| --- |
| |
| CA Comments |
| |

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

Goldsworthy
chiropractic & wellness centre

## 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 cancelled before the scheduled appointment time on the previous Thursday.

# Full treatment price will be charged for appointments missed, cancelled, 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: _____

Dr. Jeff Goldsworthy
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo Ontario N2J 4R9
Telephone: 519-884-4814