BURNABY HEIGHTS
Integrative
HEALTHCARE

DOCTOR OF CHIROPRACTIC
4353 HASTINGS STREET BURNABY, BC V5C 2J7
TEL: 604.293.2941 FAX: 604.298.2941
WWW.BHIHC.COM

CHIROPRACTIC NEW PATIENT FORM

FULL NAME:			
DATE OF BIRTH (DD/MM/YYYY):		CARE CARD NUMBER:	
STREET ADDRESS:		CITY:	
PROVINCE:		POSTAL CODE:	
HOME PHONE: (CHECK WHICH PREFERRED)	☐	CELL PHONE:	☐
WORK PHONE:	☐	OTHER:	☐
EMAIL ADDRESS:			
NEW LEGISLATION REQUIRES THAT WE OBTAIN CONSENT PRIOR TO SENDING EMAILS TO OUR PATIENTS.		EMAIL CONSENT:	☐ YES ☐ NO
OCCUPATION:			
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT NUMBER:	
PHYSICIAN'S NAME:		PHYSICIAN'S NUMBER:	
EXTENDED HEALTH CARE COMPANY:			
HOW DID YOU HEAR ABOUT OUR CLINIC? ☐ FRIEND ☐ WEBSITE ☐ SIGN ☐ OTHER:			
HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? ☐ YES ☐ NO			
NAME OF PAST CHIROPRACTOR:		REASON FOR TREATMENT:	
RESULTS:	☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR		

REASON FOR VISIT

REASON FOR VISIT:			
ON THE DIAGRAM BELOW, PLEASE LABEL THE AREAS THAT ARE BOTHERING YOU:			
IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT OR WORKPLACE INJURY? (IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK FOR ICBC OR WCB)			☐ YES ☐ NO
WHEN DID YOUR SYMPTOMS BEGIN?		WHAT WAS THE CAUSE (IF KNOWN)?	
DO YOU HAVE A PREVIOUS HISTORY OF THIS CONDITION?		DESCRIBE THE PAIN:	☐ STABBING ☐ SHOOTING ☐ BURNING ☐ NUMBNESS/ TINGLING ☐ OTHER (PLEASE DESCRIBE)

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HOW OFTEN DOES IT OCCUR?		WHAT MAKES YOUR PROBLEM BETTER OR WORSE?	
IS THIS CONDITION INTERFERING WITH YOUR:	☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ SPORTS/EXERCISE ROUTINE		
OTHER HEALTHCARE PRACTITIONERS SEEN FOR THIS CONDITION:			
☐ MEDICAL DOCTOR ☐ NATUROPATH ☐ PHYSICAL THERAPIST ☐ REGISTERED MASSAGE THERAPIST ☐ OTHER			

MEDICAL HISTORY

PLEASE INDICATE IF YOU SUFFER OR HAVE SUFFERED FROM ANY OF THE FOLLOWING:					
	ABDOMINAL PROBLEMS		DISLOCATIONS		NUMBNESS OR TINGLING
	ARTHRITIS		DIZZINESS		OSTEOPOROSIS/LOW BONE DENSITY
	ASTHMA		FRACTURES		PSYCHIATRIC OR PSYCHOLOGICAL CARE
	ARTIFICIAL JOINT		GASTROINTESTINAL DISORDER		RECENT WEIGHT LOSS/GAIN
	BALANCE PROBLEMS		HEADACHES		RESPIRATORY CONDITION
	BLURRED OR DOUBLE VISION		HEART DISEASE/FAMILY HISTORY OF		SEIZURES
	CANCER/HISTORY OF/FAMILY HISTORY OF		HERNIATED DISC		SKIN CONDITION
	CHEST PAIN		HIGH/LOW BLOOD PRESSURE		SHORTNESS OF BREATH
	CONCUSSION		JOINT STIFFNESS		SLEEP DISORDER
	DEPRESSION		NAUSEA/VOMITING		STROKE
	DIABETES		NECK OR BACK PAIN		ULCERS
	DIFFICULTY SWALLOWING		NEUROLOGICAL DISORDER		VASCULAR DISEASE

PLEASE LIST ANY SURGERIES, ACCIDENTS AND INJURIES: (WITH APPROXIMATE DATES)			
PLEASE LIST ALL MEDICATIONS AND/OR SUPPLEMENTS YOU ARE CURRENTLY TAKING:			
PLEASE LIST ANY XRAYS OR OTHER TESTING PERFORMED RECENTLY: (WITH APPROXIMATE DATES)			
PLEASE LIST ANY ILLNESS OR CONDITIONS THAT RUN IN YOUR IMMEDIATE FAMILY: (SUCH AS HEART DISEASE, CANCER, DIABETES, ARTHRITIS, AUTOIMMUNE DISORDERS OR OTHERS)			
IS THERE ANYTHING ELSE THE DOCTOR SHOULD KNOW ABOUT YOUR HEALTH?			
DO YOU PARTICIPATE IN A REGULAR EXERCISE PROGRAM? WHAT TYPE OF ACTIVITY? HOW MANY HOURS PER WEEK?			
DO YOU GET ENOUGH SLEEP?	☐ YES ☐ NO	IF NO, IS IT DUE TO PAIN?	
HAVE YOU HAD ANY RECENT CHANGES IN YOUR BOWEL OR BLADDER HABITS?			
DO YOU SMOKE?	☐ YES ☐ NO	IF YES, HOW MANY CIGARETTES PER DAY? FOR HOW LONG?	
ARE THERE ANY SIGNIFICANT STRESSORS IN YOUR LIFE?	☐ YES ☐ NO	HOW DO YOU HANDLE STRESS?	

FEMALES ONLY

ARE YOU PREGNANT?	☐ YES ☐ NO	HAVE YOU REACHED MENOPAUSE?	☐ YES ☐ NO
HAVE YOU HAD A BONE DENSITY TEST?	☐ YES ☐ NO	DATE/RESULTS:	

Your appointment time is reserved for you. Please note that to cancel or reschedule your appointment, a minimum of 24 hours notice is required to avoid a late cancellation fee of $25.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a

damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

____
Name (Please Print)

_________________________________ Date: _______________ 20____
Signature of patient (or legal guardian)

_________________________________ Date: _______________20____
Signature of Chiropractor

For Patients with Extended Health Benefits
Insurance Providers include: Great-West Life, Sun Life, Standard Life, Johnson Inc., Industrial Alliance, Chamber of Commerce, Maximum Benefit, Manulife, Desjardins, and Blue Cross

Benefit Assignment Form

Insurance Company**:** ______________________________

Patient Name: ____________________________________ Date of Birth: ___________

Policy Number: ____________________________________

Member ID Number: _______________________________

If you are not the insured member, then please provide insured member name and date of birth.

Insured Member Name: ___________________________ Date of Birth: ___________

I hereby assign benefits payable for the eligible claims to the **Burnaby Heights Integrative HealthCare, Inc (the Provider)** responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Credit Card: Visa/Mastercard: _______________________________ Exp:__________

Date: ____________

Signature: ____________________________ Print Name: _______________________

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