Advance Chiropractic
Vic Weatherall, DC

505 St-Lawrence St.
Merrickville, ON K0G 1N0
(613) 269-4663

PATIENT ENTRANCE FORM

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Tel _____ Bus. Tel. _____

Date of Birth (D/M/Y) _____ Age _____ Marital Status - S M D W S

Spouse's Name _____ Children _____

Occupation (Your) _____

Employer _____

Address _____

City _____ Phone _____

Closest Relative _____ Phone _____

Provincial Health Card Number _____ Letter Code _____

Extended Health Care Company _____

Policy # _____

How did you hear about our office: friend ☐ phone book ☐ sign ☐ other _____

CLAIM WILL BE MADE AGAINST:

1. Recent motor vehicle accident: Yes No *(if Yes, see attached)*
2. Work related injury/accident Yes No *(if Yes, see attached)*

PRIOR CHIROPRACTIC CARE:

Name: _____ Telephone: _____

X-rays taken: YES NO Date: _____

Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name: _____ Telephone: _____

Address _____

Date of Last Appointment _____ Date of Last Physical: _____

Side 1

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Reason for consulting this office: _____

_____

_____

Expectations: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

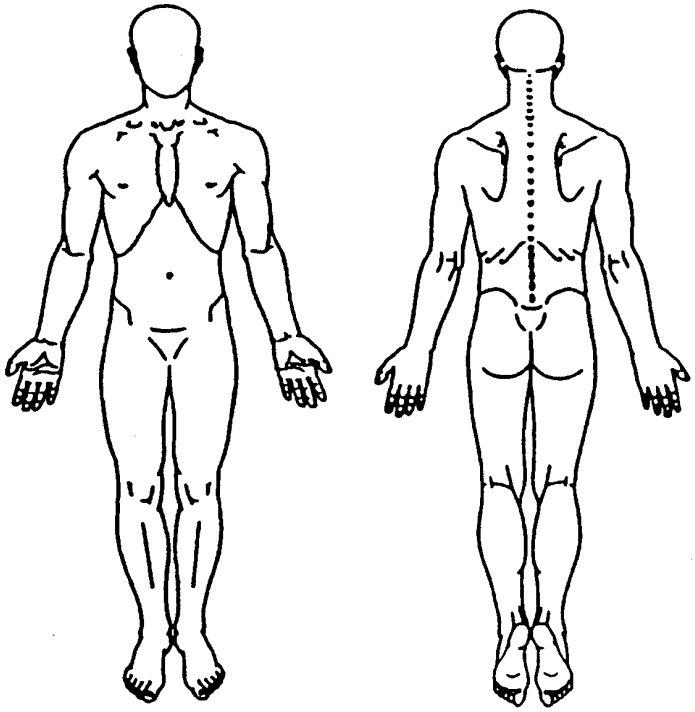
Numbness • • • • •
• • • • •
• • • • •

Pins & Needles 0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /



Have you ever had any of the following:

aneurysm _____ ostheoporosis _____ diabetes _____ arthritis _____

respiratory conditions _____ epilepsy _____ cancer _____

strokes _____ allergies _____ heart conditions _____

hepatitis _____ nerves _____ fatigue _____ polio _____

sleeping difficulty _____ pneumonia _____ pleurisy _____

asthma _____ V.D. _____ psoriasis _____ HIV _____

sinus conditions _____

Childhood conditions had, please check:

- ❑ measles
- ❑ mumps
- ❑ chicken pox
- ❑ whooping cough
- ❑ scarlet fever
- ❑ diphtheria
- ❑ rheumatic fever
- ❑ typhoid fever
- ❑ ear infections
- ❑ tubes in ears
- ❑ chronic ill

Side 2

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PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

O	F	C	
☐	☐	☐	fatigue
☐	☐	☐	allergy
☐	☐	☐	chills
☐	☐	☐	convulsions
☐	☐	☐	dizziness
☐	☐	☐	fainting
☐	☐	☐	fevers
☐	☐	☐	headaches
☐	☐	☐	loss of sleep
☐	☐	☐	nervousness
☐	☐	☐	depression
☐	☐	☐	neuralgia
☐	☐	☐	numbness
☐	☐	☐	sweats
☐	☐	☐	weight change
☐	☐	☐	tremors

MUSCLE & JOINT

☐	☐	☐	arthritis
☐	☐	☐	bursitis
☐	☐	☐	foot trouble
☐	☐	☐	hernia
☐	☐	☐	low back pain
☐	☐	☐	neck pain
☐	☐	☐	neck stiffness
☐	☐	☐	pain between shoulders
☐	☐	☐	local or generalized weakness

RESPIRATORY

☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	spitting blood
☐	☐	☐	throat phlegm
☐	☐	☐	wheezing

EYES, EARS, NOSE & THROAT

☐	☐	☐	colds
☐	☐	☐	crossed eyes
☐	☐	☐	deafness
☐	☐	☐	dental decay
☐	☐	☐	asthma
☐	☐	☐	ear aches
☐	☐	☐	ear discharges
☐	☐	☐	ear noises
☐	☐	☐	see flashes or stars
☐	☐	☐	dark spots

O	F	C	
☐	☐	☐	blurred vision
☐	☐	☐	sinus infections
☐	☐	☐	enlarged glands
☐	☐	☐	enlarged thyroid
☐	☐	☐	sore throats
☐	☐	☐	tonsillitis
☐	☐	☐	eye pain
☐	☐	☐	failing vision
☐	☐	☐	far sighted
☐	☐	☐	gum trouble
☐	☐	☐	hay fever
☐	☐	☐	hoarseness
☐	☐	☐	nasal obstruction
☐	☐	☐	near sighted
☐	☐	☐	nosebleeds

CARDIO-VASCULAR

☐	☐	☐	rapid heart beats
☐	☐	☐	slow heart beat
☐	☐	☐	swelling of ankles
☐	☐	☐	hardening of arteries
☐	☐	☐	high blood pressure
☐	☐	☐	low blood pressure
☐	☐	☐	pain over heart
☐	☐	☐	poor circulation
☐	☐	☐	irregular heart beats

GASTRO INTESTINAL

☐	☐	☐	excessive hunger
☐	☐	☐	burping or gas
☐	☐	☐	liver trouble
☐	☐	☐	colitis
☐	☐	☐	colon trouble
☐	☐	☐	constipation
☐	☐	☐	diarrhea
☐	☐	☐	difficult digestion
☐	☐	☐	distension of abdomen
☐	☐	☐	stomach pain
☐	☐	☐	gall bladder trouble
☐	☐	☐	hemorrhoids
☐	☐	☐	intestinal worms
☐	☐	☐	jaundice
☐	☐	☐	poor appetite
☐	☐	☐	nausea
☐	☐	☐	vomiting
☐	☐	☐	vomit blood

O	F	C	
SKIN			
☐	☐	☐	boils
☐	☐	☐	bruise easily
☐	☐	☐	dryness
☐	☐	☐	hives or allergy
☐	☐	☐	itching
☐	☐	☐	skin rash
☐	☐	☐	varicose veins
☐	☐	☐	infections
GENITO-URINARY			
☐	☐	☐	bet wetting
☐	☐	☐	blood in urine
☐	☐	☐	frequent urination
☐	☐	☐	loss control urine
☐	☐	☐	kidney infection
☐	☐	☐	painful urination
☐	☐	☐	prostate trouble
☐	☐	☐	pus in urine
☐	☐	☐	smell of urine

PAIN OR NUMBNESS IN:

☐	☐	☐	shoulders
☐	☐	☐	arms
☐	☐	☐	hands
☐	☐	☐	hips
☐	☐	☐	legs
☐	☐	☐	knees
☐	☐	☐	ankles
☐	☐	☐	feet
☐	☐	☐	painful tail bone
☐	☐	☐	sciatica
☐	☐	☐	swollen joints

FOR WOMEN ONLY

☐	☐	☐	cramps
☐	☐	☐	heavy flow
☐	☐	☐	light flow
☐	☐	☐	irregular cycle
☐	☐	☐	painful cycle
☐	☐	☐	discharge
☐	☐	☐	sore breasts

Menopausal: ☐ Yes ☐ No
Last menstration date:

_____

Pregnant: ☐ Yes ☐ No
due date: _____

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PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you use recreational drugs: ❑ Yes ❑ No

Do you smoke: ❑ Yes ❑ No

Do you consume alcohol: ❑ Yes ❑ No

Do you exercise: ❑ Yes ❑ No

Exercise Indoor Activities:

Exercise Oudoor Activities: _____

Rate your sleep, hours per night: 4 - 6 6 - 8 8 - 10 12+

Do you wake rested: ❑ Yes ❑ No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals

Date of last Dental Examination: _____

Falls and Accidents - list: _____

_____

Surgery and Operations - list: _____

_____

Surgery recommended but not performed, list: _____

_____

Do you take vitamins and minerals, list: ❑ Yes ❑ No

_____

Have you ever been knocked unconscious: ❑ Yes ❑ No ❑ Don't know

If so, for how long: _____

List any medication or drugs you are currently taking: _____

_____

_____

Have you previously been hospitalized: ❑ Yes ❑ No

Please list: _____

Any family health conditions or problems: ❑ Yes ❑ No

Please list: _____

Rate your stress level: **Low** **Moderate** **High**

Signature: _____ Date: _____

SIDE 2

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Letter of understanding

I, _____, understand the fees to be charged to me, or my insurance, or both, for treatment by Dr. Weatherall. These fees may vary over a period of time but not without due notice to me and prior to an appointment. I understand that payment is due on the date of the appointment unless other arrangements have been made with Dr. Weatherall. Any charges resulting from a dishonoured payment are my responsibility.

I understand that Workplace Safety and Insurance Board (WSIB), provincial and personal supplemental health insurance, and accident insurance policies are an arrangement between these insurers and myself. I understand that payment for all services rendered by Dr. Weatherall are entirely my responsibility.

I understand that Dr. Weatherall or his assigned agent will help prepare any necessary documentation to assist me in collecting any due reimbursement from my insurer(s). In the case where payment is made directly from the insurer(s) to Advance Chiropractic, these monies will be applied to my outstanding balance.

I understand that to provide me with chiropractic and related goods and services, Advance Chiropractic will collect some personal information about me (for example, my home and work addresses and telephone numbers, health history and status, and health insurance numbers). I also understand that my files will be kept confidential except as required by law and the College of Chiropractors of Ontario, the governing body for Ontario's chiropractors. Release of my personal information is regulated under the Personal Health Information Protection Act (PHIPA) of Ontario. Our *Privacy statement* is found on the reverse of this page. A complete copy of our *Privacy policy* is available for viewing in the office and on the office website at *www.advancechiro.on.ca*.

I understand that it is my responsibility to contact Advance Chiropractic at least 24 hours prior to any change in a scheduled appointment and that failure to do so may result in a charge for the missed appointment. I understand that I may discontinue treatment at any time; however, it is not appropriate to discontinue without communicating with Dr. Weatherall as it causes undue concern.

Signature: _____
(patient / parent / guardian)

Date: _____

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Privacy statement

At Advance Chiropractic we are bound by law and ethics to safeguard your privacy and the confidentiality of your personal information.

This includes:

- collecting only the information that may be necessary for your care
- keeping accurate and up-to-date records
- safeguarding the medical records in my possession
- sharing information with other health-care providers and organizations on a "need to know" basis where required for your health care
- disclosing information to third parties only with your express consent, or when necessary for legal reasons
- retaining and destroying records in accordance with the law

Your request for care also requires your consent for our collection, use and disclosure of your personal information for purposes related to your care. As noted above, other purposes require your prior consent.
You have the right to see your records. You may also obtain copies of your records. Should you wish to do so, there is a fee associated with copying your file. Please contact Dr. Weatherall if you have concerns about the accuracy of your records.

If you would like to discuss our privacy policy in more detail, or have specific questions or complaints about how your information is handled, please contact to Dr. Weatherall. If you are not satisfied, you have the right to complain to the Information and Privacy Commissioner of Ontario if you think we have violated your rights. Contact the Information and Privacy Commissioner of Ontario at

Information and Privacy Commissioner of Ontario
2 Bloor Street East
Suite 1400
Toronto, Ontario
M4W 1A8
Telephone: (416) 326-3333 or 1(800) 387-0073.

Adapted from the OMA Privacy Statement, www.oma.org/phealth/privacymain.htm