THE PURPOSE OF OUR CHIROPRACTIC OFFICE IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM STATE OF WELL BEING AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN RETURN EDUCATE OTHERS.

Why Chiropractic? People go to the Chiropractor for a variety of reasons. Some go for symptomatic relief of pain or discomfort (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 (Preventive/Wellness care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his prepared recommendation is an incorporation of all three phases.

Please Check one:

❑ Relief Care ❑ Corrective Care ❑ Preventative/Wellness Care

❑ Check here : If you want the doctor to select the type of care appropriate for your condition

Agreements

Consent for Chiropractic Consultation and Examination.

I hereby request and consent to the performance of a chiropractic consultation and examination, other chiropractic procedures and if necessary diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone authorized by the same doctor. I have read this consent and have had the opportunity to discuss this with the doctor.

Office Fees

1st visit: Consultation, Examination, Computerized Scans,X-Rays(if needed)	$_____
Regular Office Visit	$_____
Computerized Scans	$_____

X-Ray fees range from $_____ to $_____ depending on views

Finances

Payment is due when services are rendered, however we do have an express checkout program whereby a patient can prepay for care and enjoy both a speedy checkout and a significant discount as well. If you have insurance coverage, we will be happy to provide you with a statement that you can send directly to your insurance company for reimbursement.

Signature _____ Print: _____

Witness _____ Date: _____

❑ Dr. B. Szczurko

THOROLD CHIROPRACTIC **CENTRE**

35 Albert Street West
Thorold, Ontario L2V 2G4
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Welcome to Our Office

Our Intent: To maximize your body's ability to heal itself naturally.
To educate you how to do it.

Our Approach: Neurologically Based with emphasis on lifestyle enhancement by addressing physical, chemical and emotional/mental stresses.

Outline of Office Procedures

1. **Step One:**
   All new patients are requested to fill out a personal health/history questionnaire

2. **Step Two:**
   Your first consultation with the Doctor: to determine your health needs and quality of life issues.

3. **Step Three:**
   Chiropractic, Orthopedic and Neurological examinations : to determine how chiropractic can best serve you.

4. **Step Four:**
   The Doctor will advise you as to the need of additional procedures such as X-Ray tests or referral for other necessary procedures.

5. **Step Five:**
   You will be given a "Report of Findings" on your second scheduled visit. The Doctor will explain your examination results and type of care most appropriate for your specific needs.

6. **Step Six:**
   After you receive your report of findings our staff will explain office procedures, financial policies and schedule of care which includes a special appointment for you. (We suggest your spouse or significant other attend with you.)

7. **Step Seven:**
   Adjustments will begin and continue as scheduled until maximum correction for you has been achieved at which point a schedule of care for wellness/maintenance will be recommended.

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Name: _____ Pt Number _____ Date:_____ D M Y _____
Address_____
City: _____ Province: _____ Postal Code_____
Home Phone: (___) _____ Cell Phone: (___) _____ Business Phone: (___) _____
email: _____
Birth Date:_____ D M Y _____ Sex: ❑M ❑F Height: _____ Weight:_____
Business/Employer _____ Type of Work_____
Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated ❑Common Law
No. of Children_____ Ages:_____
Referred to this Office By: _____ Spouse's Name:_____
Is this for the whole family? ❑Family ❑Self Childrens' Name(s):__ _____
_____

Primary Quality of Life Issue:

Purpose of this Appointment: _____
Major Complaint _____
Other Drs seen for this condition _____
How long has this been going on: Hours___ Days:___ Weeks:___ Months:____ Years:_____
Any previous occurences- when?:_____
How was it treated?:_____
Are there others in your family with the same condition:_____

If disabled from work please give dates: _____
❑Job related ❑Auto related Date of Accident/Injury _____
How did it occur?_____

Current Health Challenge Information

The Pain is:	❑ Sharp	❑ Dull	❑ Travels	❑ Constant
Since the Onset is the Pain:	❑ Worse	❑ Better	❑ Same	❑ On & Off
The Pain is worse with:	❑ Standing	❑ Sitting	❑ Lying	❑ Movement
Are any of your systems involved:	❑ Digestive	❑ Respiratory	❑ Elimination	❑ Nervous
	❑ Cardiovascular	❑ Reproductive		

Severity of Pain at its Worst (Please Circle) 1= best, 10= worst

1 2 3 4 5 6 7 8 9 10

Current Severity of Pain (Please Circle) 1= best, 10= worst

1 2 3 4 5 6 7 8 9 10

Quality of Life Issues:

How does your current condition affect your :

Work
❑ Lost Time ❑ Lost Focus ❑ Lost Productivity
Relationships
❑ Short Tempered ❑ Unable to play with Kids
Recreational
❑ Unable to play Sports ❑ Other Activities
Daily Activities
❑ Watching TV ❑ Shopping ❑ Sleeping
❑ other_____

Any other facts about your current condition or health status?
_____
_____
_____

Please use the diagram to indicate the areas of the problem.

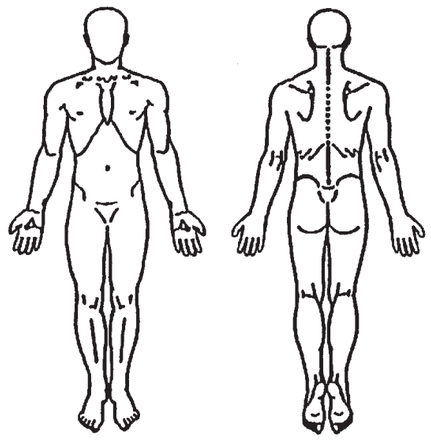

Diagram Key:
A=Ache P=Pins & Needles
S=Stabbing N=Numbing
B=Burning O=Other

Names of Allied Health Professionals: MD_____ Naturopath_____
Optometrist_____ Dentist_____
Surgeons:_____
Specialists:_____
Professional Counsellors:_____
Medication you now take: _____
Vitamins/Supplements: _____
Medications taken in past:_____

Injury History:

Hospital Birth	❑ Yes ❑ No	If No, please describe:	_____
Do you play any sports?	❑ Yes ❑ No	If Yes, which ones?	_____
Have you ever broken a bone:	❑ Yes ❑ No	If Yes, which ones?	_____
Any serious falls as child or adult?	❑ Yes ❑ No	If Yes, how?	_____
Have you ever lost consciousness?	❑ Yes ❑ No	If Yes, how?	_____

Have you had any motor vehicle accidents ❑ Yes ❑ No If Yes, please note type and year, even if minor:
_____
_____
Any other accidents?_____
Please list any surgeries, including minor:
❑Appendix ❑Tonsils ❑Gall Bladder ❑Hernia ❑Heart ❑Spine ❑Hysterectomy ❑Tubal Ligation
❑Bowel ❑Bladder ❑Eyes ❑Ears ❑Hip ❑Knee ❑Shoulder ❑Elbow ❑Wrist
Other:_____

Past Health History

History of Illnesses:
_____
_____
Hospitalization (Other Than Surgery) _____
Any ❑Allergies:_____ ❑Eczema ❑Rashes ❑Breathing Difficulties
Previous Chiropractic Care: Doctor's Name _____When_____
Have You been treated For Any Health Condition in the last year? ❑Yes ❑No
If Yes, Please Explain_____
Does Anyone else in your family have the same or similar condition? _____

Please Check all your warning signs even if not seemingly related to your complaint:

❑ frequent colds	❑ ADD	❑ headaches	❑ fevers
❑ cold hands/feet	❑ poor concentration	❑ narcolepsy	❑ fatigue
❑ anxiety	❑ hypoglycemia	❑ seizures	❑ MS
❑ ulcers	❑ irritability	❑ sleep walking	❑ Epstein-Barr syndrome
❑ bowel problems	❑ impulsivity	❑ hot flashes	❑ Fibromyalgia
❑ restless sleep	❑ distraction	❑ allergies	❑ depression
❑ nervousness	❑ low energy	❑ bipolar disorder	❑ Rheumatoid arthritis
❑ high BP	❑ disorganization	❑ eating disorders	❑ Chronic Fatigue Syndrome
❑ tight muscles	❑ low pain threshold	❑ bed wetting	❑ Auto-immune system disorders
❑ accelerated aging	❑ incontinence	❑ mood swings	
❑ heart palpitations	❑ muddledness	❑ panic attacks	
❑ poor expression of emotions	❑ poor awakening	❑ PMS	

Lifestyle Issues: Check Appropriate Items

❑ Smoke: #/day now _____ before_____		❑ Regular Bowel Movements: #/day___	
❑ Coffee: #/day_____	❑ Bottled Water: #/day_____	❑ Fast Foods: #/wk ____	❑ Vegetarian
❑ Tea: #/day_____	❑ Alcohol: #/day_____	❑ Exercise: #/wk_____	❑ Rested ❑ Always Tired
❑ Pop: #/day now_____			