

# meridian WELLNESS

Patient Information & History

Date: \_\_\_\_\_

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PATIENT INFORMATION

Name: \_\_\_\_\_ Birthday (D/M/Y): \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
(First) (Initial) (Last)

Address: \_\_\_\_\_  
(Street) (Apt/Ste #) (City) (Postal Code)

Home phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Single  Married Occupation: \_\_\_\_\_

Parent/Guardian's Name (if a minor): \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**How did you hear about us?**

- Sign
- Yellow pages
- Internet
- Radio
- Magazine
- Friend \_\_\_\_\_
- Seminar
- Dr. \_\_\_\_\_
- Other \_\_\_\_\_

2

ACCIDENT INFORMATION

Is your condition due to an accident?  No  Yes Date: \_\_\_\_\_

Type of accident?  Automobile  Work  Home  Other

To whom have you reported the accident? \_\_\_\_\_

Insurance  Worker's Comp  Employer  Other

Attorney Name (if applicable) \_\_\_\_\_

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PATIENT CONDITION

What is your major symptom/problem? \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_

Is your condition getting progressively worse?  Yes  No

Is the problem:  constant  comes and goes

How does it feel?  Burning  Sharp  Shooting  Dull  Aching  Stiff

Tingling  Throbbing  Swelling  Other \_\_\_\_\_

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? \_\_\_\_\_

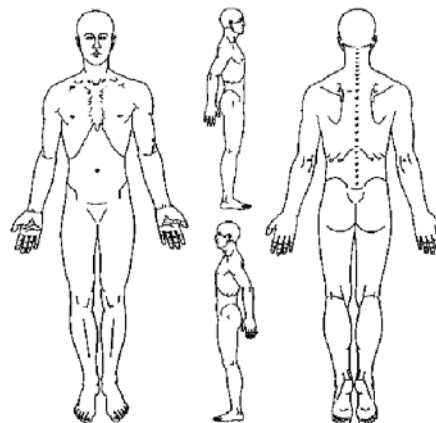
What makes your condition worse? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities/movement that are painful to perform:

Sitting  Standing  Walking  Bending  Lying down  Driving  Reading  Getting Up

Please mark where the pain is located



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## HEALTH HISTORY

What other treatments have you had for this condition? \_\_\_\_\_

- Chiropractic  
 Orthopedic  
 Neurologist  
 Physical Therapy  
 Medication  
 Surgery  
 Other

Name of other doctors who have treated you for this condition \_\_\_\_\_

Describe the other doctor's treatment for your condition \_\_\_\_\_

Previous Chiropractic care?  No  Yes    Date \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ MRI \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Dental x-ray \_\_\_\_\_ CT-Scan \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

Vitamins/Herbs/Minerals \_\_\_\_\_

**Females:** Are you Pregnant?  Yes  No    Beginning of last menstrual cycle \_\_\_\_\_

### Check any of the following conditions you have had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Ear ringing         | <input type="checkbox"/> Neck pain            |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Anxiety/Depression   | <input type="checkbox"/> Falls/Head injuries | <input type="checkbox"/> Poor circulation     |
| <input type="checkbox"/> Arm/shoulder pain    | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Prostate problems    |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Sciatica             |
| <input type="checkbox"/> Automobile accidents | <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> Bladder problems     | <input type="checkbox"/> Herniated disk      | <input type="checkbox"/> Sinus infection      |
| <input type="checkbox"/> Broken bones         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Surgeries            |
| <input type="checkbox"/> Chronic fatigue      | <input type="checkbox"/> Irregular cycle     | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Deafness             | <input type="checkbox"/> Kidney problems     | <input type="checkbox"/> TMJ                  |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Leg pain            | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Digestion problems   | <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Vertigo/dizziness    |
| <input type="checkbox"/> Earache              |  |   |

### STRESSORS

- |   |                   |
|---|-------------------|
| <input type="checkbox"/> Smoking                | Packs/Day _____   |
| <input type="checkbox"/> Alcohol                | Drinks/Week _____ |
| <input type="checkbox"/> Coffee/Caffeine Drinks | Cups/Day _____    |
| <input type="checkbox"/> High Stress Level      | Reason _____      |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

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## AUTHORIZATION

The services provided by our chiropractor are not covered by OHIP. If you have extended health insurance coverage, you may get reimbursed for certain procedures. However, it is the responsibility of the patient to determine their coverage, pay this clinic directly, and then submit the receipts to their respective insurance provider.

Payment methods accepted are: VISA, MasterCard, Direct Debit (Interac), Cash or Cheque.

We cannot guarantee the number of treatments you will require to heal your condition of the affected area. However, to achieve the best results we highly recommend that you follow the treatment plan that is laid out for you by our Chiropractor. Missed or skipped appointments can result in longer healing times or lackluster results. A 24-hour cancellation notice is required, otherwise the regular appointment fee will apply.

I have read and understood the above information pertaining to procedures and payment policies of Meridian Wellness Group Inc. and agree to abide by these policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if patient is a minor)

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

- a) While rare, some patients have experienced rib fractures or muscle and ligament sprains/strains following spinal adjustments;
- b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

**PLEASE READ BEFORE SIGNING**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Stay Informed & Protect our Environment!**

In our effort to save paper and trees, we will be transitioning to sending monthly updates to our patients electronically. You will find these updates valuable as they contain information about clinic changes and recent news, as well as up-to-date advisories/recalls on herbs and supplements. Occasionally, we may need to contact you by email if we cannot reach you by phone. Your email will remain confidential with us and you may unsubscribe at any time. Please check the appropriate box and print your email on the first page if applicable.

Yes, I would like updates by email

No, I would prefer to receive paper updates.