Dr. Joe Mondoux
Chiropractor

Patient Information (Please Print)

Name: _____ Gender: _____

Address: _____ City _____

Province: _____ Postal Code: _____ Home Phone: _____ Cell Phone: _____

Birth Date (D/M/Y): _____/_____/_____ Age: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Email for Appointment Time Reminder: _____

Emergency contact: _____ Phone Number: _____

Have you attended another chiropractor? ☐ Y ☐ N Name: _____

When: _____ Reason for visit: _____

Have you had acupuncture before? ☐ Y ☐ N Reason: _____

Do you have any blood conditions such as HIV, Hepatitis, etc.? _____

Referred by: _____

Employer Information

Employer: _____ Occupation: _____

Physician Information

Medical Doctor: _____ City: _____

May we contact and/or send medical information to your medical doctor? ☐ Y ☐ N

DJC Integrative Therapy
262 Lauzon Rd.
Windsor, ON N8S 3L6
T: 519-735-8400 F:519-735-7341

Information of Condition

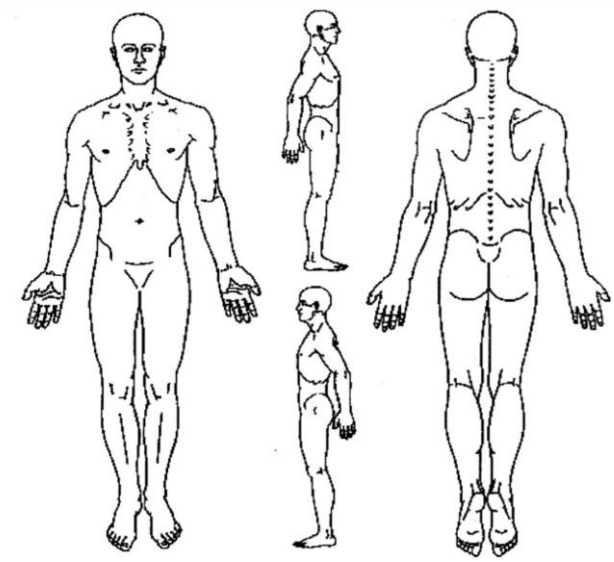
What is the main reason for this visit? _____

When did this problem start? _____ How? _____

Any additional complaints? _____

On the diagram below, please indicate where you are experiencing pain right now and use the appropriate symbol as indicated

Ache	//////////
Burning	BBBBB
Numbness	NNNNN
Pins & Needles	++++++
Stabbing	XXXXX
Stiffness	^^^^^^^
Weakness	WWWW



Please make a slash through this line as to the level of your current pain

No Pain At All |----------| Worst Pain Possible

The symptoms are (Please Circle): Constant Intermittent Worse with movement Better with movement Worse in the a.m. Worse in the p.m. Getting better Getting worse No change

I am experiencing (Please Circle): Numbness Weakness Swelling Weight changes Night Sweats Fever Changes in bowel/bladder frequency or urgency

What makes your symptoms worse? (Please Circle) Standing Walking Lifting Exercise Twisting Bending Sitting Coughing/Sneezing Lying Down: Side Back Stomach Using Stairs: Up Down Both Other: _____

What makes your symptoms better? **(Please Circle)** Rest Elevation Ice Heat Position: _____ Other: _____

Medications/Vitamins/Supplements: _____

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Past Medical History

Have you ever been in an automobile accident? ☐ Y ☐ N Date: _____

Any difficulties/injuries resulting from this incident? _____

Please list surgeries and year performed: _____

Please indicate if you have ever had any of the following?

Cardiovascular

- ☐ High/Low Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Aneurysm
- ☐ Pace Maker
- ☐ Heart Disease
- ☐ Other:_____

Respiratory

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Other: _____

Infection

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Skin
- ☐ Chicken Pox
- ☐ Other: _____

Head/Neck

- ☐ Headaches
- ☐ Migraines
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Sinus Condition
- ☐ Other: _____

Previous Injuries

- ☐ Head/Neck
- ☐ Upper Back
- ☐ Mid Back
- ☐ Lower Back
- ☐ Shoulders/Arms
- ☐ Wrist/Hands/Fingers
- ☐ Pelvis
- ☐ Legs/Knees
- ☐ Ankles/Feet/Toes

Other Conditions

- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis: OA/RA
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Psoriasis
- ☐ Fibromyalgia
- ☐ Fatigue
- ☐ Concussion
- ☐ Allergies: _____
- ☐ Other: _____

Women

Are you currently pregnant? ☐ Y ☐ N

If yes, due date: _____

Signature: _____ Date: _____

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Patient Information and Consent Form
For Acupuncture Treatment

Please read this information carefully and ask your practitioner if there is anything that you do not understand.

What is acupuncture?
Acupuncture is a form of therapy in which fine, single use needles are inserted into specific point s on the body and electrical stimulation is added.

Is acupuncture safe?
Acupuncture is generally very safe. Serious side effects are very rare- less than one per 10,000 treatments, including pneumothorax, spinal cord lesions, nerve damage and infection

Does acupuncture have any side effects?
You need to be aware that

- Drowsiness/relaxation can occur. If so, the patient is advised not to drive.
- Minor bleeding/bruising at puncture sites can occur following treatment.
- Pain can occur during treatment.
- Aggravation of symptoms can follow initial treatments. This can be a good sign as change is occurring
- Fainting can occur during treatment, particularly during the first treatment.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important that you let your practitioner know

- If you have ever experienced any fainting spells.
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other blood thinners
- If you have damaged heart valves or have any other particular risk of infection

Single use, sterile, disposable needles are used in this clinic.

Statement of Consent
I confirm that I have read the above information, and I consent to acupuncture treatment. I understand that I can refuse treatment anytime.

NAME:_____ DATE:_____

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result 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 does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest 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 doctors 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 this 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:_____
(please print)

Name:_____
(please print)

CHIROPRACTIC FEE SCHEDULE AND MISSED APPOINTMENT POLICY

ADULTS	
INITIAL VISIT	$115.00
SUBSEQUENT	$55.00
SENIOR 65+/ CHILDREN UNDER 13	
INITIAL VISIT	$70.00
SUBSEQUENT	$45.00

We will direct bill insurance companies for motor vehicle accidents. You are responsible for submitting your required documentation and in the event they do not pay us, you will be responsible for paying the outstanding balance. Same rules apply for worker's compensation claims as for motor vehicle accidents.

We offer email reminders of your appointment as a courtesy, but it is your responsibility to be aware of appointment times. Appointments cancelled without 24-hours' notice and missed appointments will be subject to the following fees: First time – No fee. We understand mistakes happen and life can be busy so there is no charge for the first late cancellation/missed appointment. Second time - $25 charge. Third time and ongoing – Full appointment fee charge

Please allow sufficient time when planning your appointment to account for traffic, parking etc. We do our best to run on time and therefor often cannot accommodate late arrivals. Arriving late will either result in a shortened treatment time or the inability to received treatment that day at which point the above fee schedule will apply.

Plan Holder Name: _____

Carrier: (Name of the insurance) _____

Patient Name: (Your name) _____ Patient Date of Birth_____

Plan/Policy# _____

Certificate/ID# _____

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

I acknowledge and agree 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 DJC Integrative Therapy 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 DJC Integrative Therapy.

Date: _____ Signature: _____