Columbia Integrated
Health Centre

GENERAL HEALTH HISTORY QUESTIONAIRE

☐ CHIROPRACTIC ☐ MASSAGE THERAPY ☐ PHYSIOTHERAPY

Name:_____ Date:_____

Date of Birth:_____ Carecard No:_____

Address:_____ City:_____

PostalCode:_____ Email Address:_____

Home Phone: _____ Cell:_____ Work:_____

Occupation:_____

Do you wish to receive appointment reminders via: Text ☐ Email ☐ Both ☐

If you selected yes to Text appointment reminders, who is your cell phone provider?
(eg: Fido, Telus, Rogers, Bell)_____

Emergency Contact Person:_____ Phone:_____

Family Doctor:_____ Phone:_____

How did you hear about the clinic?_____

Are you coming in today regarding an ICBC or WCB claim? Yes ☐ No ☐
If you selected yes, please complete this section:

ICBC ☐ WCB ☐ Claim No:_____ Date of Injury/MVA:_____

Adjuster/Case Manager:_____ Phone No:_____

Lawyers Name:_____ Phone No:_____

What is the *main problem* you would like us to address today?

_____

_____

_____

When did you first notice any symptoms?_____

Are your symptoms currently: Getting Better ☐ Getting Worse ☐ Staying the Same ☐

Have you ever experienced these symptoms before?

_____

What is your current stress level? ☐ Low ☐ Moderate ☐ High

Is your present condition the result of a single traumatic event? If so, what happened?

_____

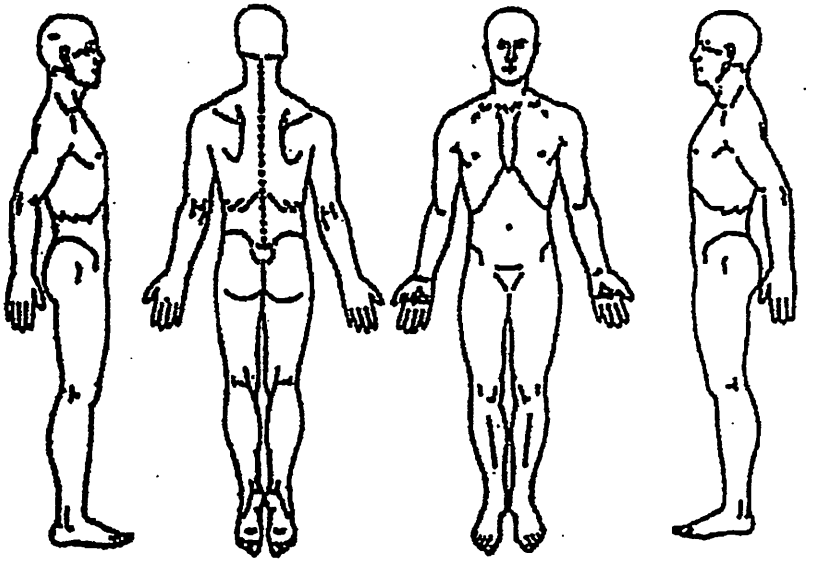
_____

What other types of treatment, if any, have you received for this condition? Did it help?

_____

_____

Please mark the area(s) on the diagram where you feel the described sensations:



Sharp Pain: XXXX Dull/Aching Pain:0000 Numbness/Tingling: *IIIIII* Shooting Pain: >>>>

What aggravates these symptoms?

☐ standing ☐ sitting ☐ lying down ☐ walking ☐ running ☐ jumping

☐ bending ☐ twisting ☐ lifting ☐ coughing ☐ sneezing ☐ bowel movements

☐ getting up from a chair ☐ other_____

What relieves these symptoms?

☐ rest ☐ ice ☐ heat ☐ stretching ☐ exercising ☐ medication ☐ other_____

Medical History:

Have you RECENTLY noted any of the following? (check all that apply)

☐ fatigue	☐ numbness/tingling	☐ constipation
☐fever/chills/sweats	☐ muscle weakness	☐ diarrhea
☐nausea/vomiting	☐ dizziness/light-headedness	☐ shortness of breath
☐ weight gain/loss	☐heartburn/indigestion	☐fainting
☐ falls	☐difficulty swallowing	☐cough
☐headaches	☐changes in bowel or bladder function	

Have you EVER been diagnosed with any of the following conditions?(check all that apply)

☐ cancer	☐ depression	☐ thyroid issues
☐ heart problems	☐ lung problems	☐ diabetes
☐ tuberculosis	☐ osteoporosis	☐ high blood pressure
☐ asthma	☐ multiple sclerosis	☐ circulation problems
☐ rheumatoid arthritis	☐ epilepsy	☐ blood cots
☐ eye problems/infection	☐ bladder/urinary tract infection	☐ stroke
☐ ulcers	☐ anemia	☐ liver problems
☐ kidney problem	☐ bone or joint infections	☐ bone fracture
☐ Hepatitis	☐ HIV	☐ drug/alcoholism
☐ pneumonia	☐ pelvic inflammatory disease	

Has anyone in your immediate family been diagnosed with any of the following?:

☐ cancer	☐ diabetes	☐ tuberculosis	☐ heart problems
☐ stroke	☐ thyroid issues	☐ high blood pressure	☐ depression

Have you ever had any broken bones? if yes, which ones?_____

Have you ever had any surgery? If yes, please describe:

_____

_____

Please list any medications you are currently taking, including vitamins and supplements:

_____

_____

Do you smoke cigarettes? if yes, approximately how many per day?_____
Do you drink alcohol? if yes, approximately how much per week?_____

If there is any other information regarding your present condition that you think my help us, please mention it here:

_____

_____

Cancellation Policy:

In consideration of other patients and my therapist, I understand that a minimum of 24 hours notice is required to change or cancel my appointment. **I am aware that is my responsibility to pay 50% of the treatment fee in the case of late cancellations or missed appointments. Cancellation fees are payable before rebooking another appointment.**

By signing below you understand that the information is true to the best of your knowledge and understand and agree to our cancellation policy:

Patient Name_____ Signature_____

Date:_____ Witness:_____

To be completed by patients eligible for MSP Premium Assistance.
*(*Please ask the front desk if you need further explanation of MSP benefits)*

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS TO COLUMBIA INTEGRATED HEALTH CENTRE

I authorize the Medical Services Plan to pay *COLUMBIA INTEGRATED HEALTH CENTRE* directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Services Plan, which will be directed to *COLUMBIA INTEGRATED HEALTH CENTRE* and be applied against any outstanding monies I owe for services provided.

This form allows your practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of their full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

I understand that any MSP benefits over and above the 10 treatments allotted per year will be my responsibility to pay.

Care Card Number (PHN):_____

Full Name (as it appears on your Care Card):

_____

Signature: _____

Date: _____

CONSENT TO CHIROPRACTIC TREATMENT

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