Stibbard Chiropractic
6975 Wyandotte St. E,
Windsor, On, N8S 1P8
Phone: (226) 506-2681
stibbardchiropractic@gmail.com
stibbardchiropractic.com

Name:_____ DOB:_____

Gender: Male Female Other:_____

Address:_____

City:_____ Province:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Emergency Contact Name:_____

Phone Number:_____ Relationship:_____

Medical Dr. Name:_____ Date of last physical:_____

Previous Chiropractor Name:_____

Permission to Contact above health care providers: Y N

How did you hear about our clinic?:_____

Private Insurance Provider: _____

Policy #:_____ Member #:_____

Name of card holder:_____

Relationship to card holder:_____

Is this a workplace injury or a motor vehicle accident?:_____ Claim Number:_____

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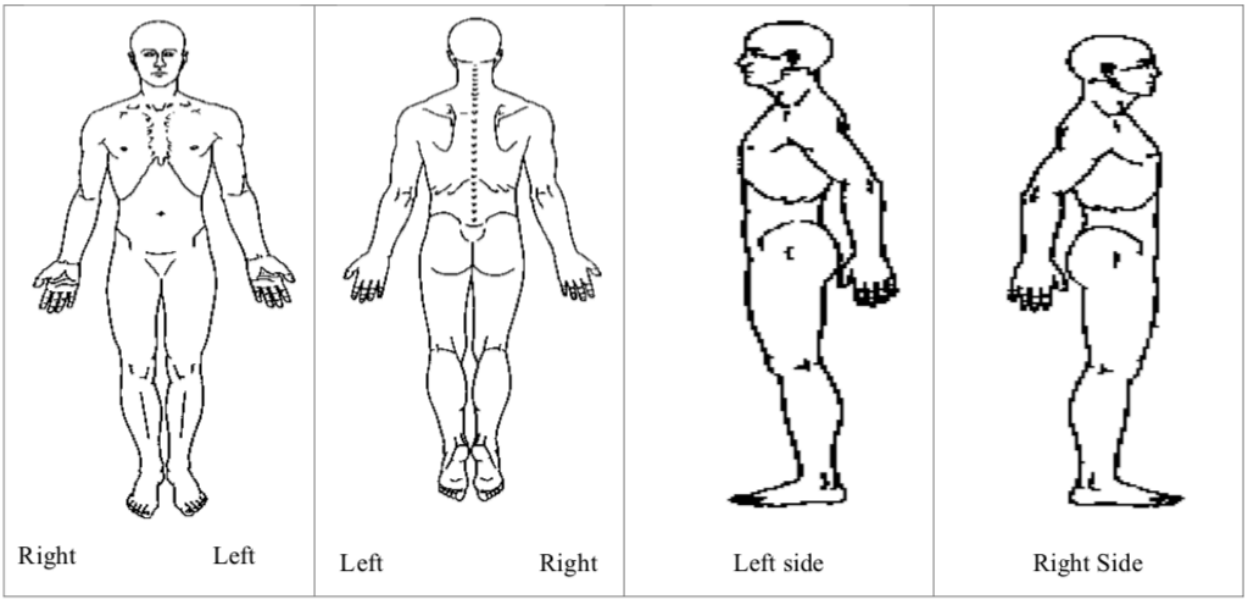
On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation(s) on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness = N
Tingling = T
Dull Pain = D
Sharp Pain = P
Burning = B
Stiffness = S



How intense is the pain right now?

0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

What is the least intense the symptom has been?

0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

What is the most intense the symptoms has been?

0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

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

C = Constant **F = Frequent** **O = Occasional**

NEUROLOGICAL	C	F	O
Allergy	☐	☐	☐
Chills	☐	☐	☐
Convulsions	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fevers	☐	☐	☐
Headaches	☐	☐	☐
Loss of Sleep	☐	☐	☐
Nervousness	☐	☐	☐
Depression	☐	☐	☐
Neuralgia	☐	☐	☐
Numbness	☐	☐	☐
Sweats	☐	☐	☐
Tremors	☐	☐	☐
Weight Loss	☐	☐	☐

MUSCLE AND JOINT	C	F	O
Arthritis	☐	☐	☐
Bursitis	☐	☐	☐
Foot Trouble	☐	☐	☐
Hernia	☐	☐	☐
Low Back Pain	☐	☐	☐
Neck Pain	☐	☐	☐
Neck Stiffness	☐	☐	☐
Shoulder Pain	☐	☐	☐

RESPIRATORY	C	F	O
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Difficulty Breathing	☐	☐	☐
Spitting Blood	☐	☐	☐
Throat Phlegm	☐	☐	☐
Wheezing	☐	☐	☐

EYES, EARS, NOSE AND THROAT	C	F	O
Colds	☐	☐	☐
Crossed Eyes	☐	☐	☐
Deafness	☐	☐	☐
Dental Decay	☐	☐	☐
Asthma	☐	☐	☐
Ear Aches	☐	☐	☐
Ear Discharge	☐	☐	☐
Ear Noises	☐	☐	☐

EYES, EARS, (CONT'D)	C	F	O
Sinus Infections	☐	☐	☐
Enlarged Glands	☐	☐	☐
Enlarged Thyroid	☐	☐	☐
Sore Throat	☐	☐	☐
Tonsillitis	☐	☐	☐
Eye Pain	☐	☐	☐
Failing Vision	☐	☐	☐
Far Sighted	☐	☐	☐
Gum Trouble	☐	☐	☐
Hay Fever	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal Obstruction	☐	☐	☐
Near Sighted	☐	☐	☐
Nosebleeds	☐	☐	☐

CARDIO-VASCULAR	C	F	O
Rapid Heart Beat	☐	☐	☐
Slow Heart Beat	☐	☐	☐
Swelling of Ankles	☐	☐	☐
Hardening of Arteries	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Pain Over Heart	☐	☐	☐
Poor Circulation	☐	☐	☐

GASTRO INTESTINAL	C	F	O
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	☐	☐	☐
Vomiting Blood	☐	☐	☐

SKIN	C	F	O
Boils	☐	☐	☐
Bruise Easily	☐	☐	☐
Dryness	☐	☐	☐
Hives or Allergy	☐	☐	☐
Itching	☐	☐	☐
Skin Rash	☐	☐	☐
Varicose Veins	☐	☐	☐

GENITO-URINARY	C	F	O
Bed Wetting	☐	☐	☐
Blood in Urine	☐	☐	☐
Frequent Urination	☐	☐	☐
Urine Control Loss	☐	☐	☐
Kidney Infections	☐	☐	☐
Painful Urination	☐	☐	☐
Prostate Trouble	☐	☐	☐
Pus in Urine	☐	☐	☐
Smell of Urine	☐	☐	☐

PAIN/NUMBNESS IN	C	F	O
Shoulders	☐	☐	☐
Arms	☐	☐	☐
Hands	☐	☐	☐
Hips	☐	☐	☐
Legs	☐	☐	☐
Knees	☐	☐	☐
Ankles	☐	☐	☐
Feet	☐	☐	☐
Painful Tailbone	☐	☐	☐
Sciatica	☐	☐	☐
Swollen Joints	☐	☐	☐

FOR WOMEN ONLY	C	F	O
Cramps	☐	☐	☐
Heavy Flow	☐	☐	☐
Light Flow	☐	☐	☐
Irregular Cycle	☐	☐	☐
Painful Cycle	☐	☐	☐
Discharge	☐	☐	☐
Sore Breasts	☐	☐	☐

Menopausal Yes ☐ No ☐
Last Menstruation Date:
Pregnant Yes ☐ No ☐
Due Date:

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List of All Current Medications:

_____

_____

_____

Previous Chiropractic Care:_____

Allergies:_____

Surgeries:_____

Hospitalizations:_____

Infections:_____

Check all that apply- Do you have a family history of:

Cancer_____Diabetes_____High Blood Pressure_____Heart Disease_____Stroke_____

Arthritis_____ Other: _____

Check all that apply- Have you experienced any recent:

Unexplained weight loss_____ Fever or night sweats____ Fatigue/Malaise_____

Loss of appetite_____ Night pain _____

Hours of Physical Activity per week:_____ If you're pregnant, how many weeks?:_____

If you smoke, how many cigarettes per day?:____

If you drink alcohol, how many drinks per week?:____

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Informed Consent For Acupuncture Care

It is important for you to consider the benefits and risks and alternatives to the acupuncture treatment offered by your chiropractor and to make an informed decision about proceeding with treatment.

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits

Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks

The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the chiropractor if you:

- Have or develop any major health issues
- Are pregnant or actively trying to be
- Are Immune compromised
- Have a bleeding disorder or take anticoagulants
- Suffer from metal allergies
- Have damaged heart valves or have a high risk of infection
- Have been fitted for a pacemaker or other electrical implants
- Have had prosthetic implants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

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Pregnancy

The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your chiropractor if you are pregnant or actively trying to be.

Alternatives

Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

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.**

I hereby acknowledge that I have read this form and 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 acupuncture treatment as proposed to me.

Today's Date:_____

_____ _____
Patient Name (Please Print) Witness Name

_____ _____
Patient Signature (or Legal Guardian) Witness Signature

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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.
- **Sprainorstrain** –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.

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● **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.

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Today's Date:_____

_____ _____
Patient Name (Please Print) Witness Name

_____ _____
Patient Signature (or Legal Guardian) Witness Signature

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Accuracy of Information

I certify that the above medical information is correct to my knowledge. _____ **Initial Here**

Privacy & Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medial information as documented above. In addition, I authorize the clinic and its associated health professionals communicate with my family doctor and/ or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. _____ **Initial Here**

Cancellation Policy

Your appointment time is reserved just for youj. A late cancellation of missed visit leaves a hole in the health professionals' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment may be subject to cancellation fee. _____ **Initial Here**

Direct Billing Consent Forms

Benefit Assignment Form

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

I acknowledge and agree that 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 the Provider 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 the Provider. _____ **Initial Here**

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Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

-use my personal information for the above purposes.
-exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
-exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
-exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/ or plan administrator and their service provider(s) to use and disclose their personal information as set out above. _____ **Initial Here**