

Confidential Patient Case History

Name: _____ Birth date: _____ Today's Date: _____

Address: _____
Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: () _____ - _____ Work Telephone Number: () _____ - _____

Email: _____ Age: _____ Male Female

Occupation: _____ Employed by: _____

Do you have extended health care? Yes No Marital Status: Single Married Divorced Widowed

Number of children: _____ Names of children: _____

Spouse's Name: _____

Have you had previous chiropractic care? Yes No Chiropractor's name: _____

Medical Doctor's name and phone number: _____

Who may we thank for referring you to our office? _____

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

| | YES | NO | UNSURE | | YES | NO | UNSURE |
|---|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Did you have any childhood illnesses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was there any prolonged use of medicine such as antibiotics or an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you have any serious falls as a child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Did you suffer any other traumas? (physical or emotional) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you play youth sports? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were you vaccinated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you take/use any drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | As a child, were you under regular Chiropractic care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you have any surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Were you involved in any car accidents as a child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

Adult Years (Age 18 to present)

| | YES | NO | | YES | NO |
|---------------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Do/did you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | Do/did you play any adult sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do/did you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | Do/did you participate in extreme sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been in any accidents? | <input type="checkbox"/> | <input type="checkbox"/> | On a scale of 1-10 describe your stress level: (1 = none, 10 = extreme) | | |
| Have you had any surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Occupational: _____ Personal: _____ | | |

On a scale of POOR, GOOD, or EXCELLENT, describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____



If you have no symptoms or complaints, and are here for wellness services, please check (✓) here and skip to "Family Health Profile". Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life, when you first noticed it, and how it originally occurred.

What is your health concern(s)? _____

If you are experiencing pain, is it (check all that apply):

- Dull Sharp Aching Cutting Throbbing Numbing Burning Tingling Cramping
 Spasm Stinging Shooting Pounding Constricting Other: _____

When did it start? _____ It is: About the Same Getting Better Getting Worse

What makes it worse? _____

How frequent is it? Constant Daily Weekly Intermittent Night Only Other: _____

How long does it last? (i.e. a few minutes etc.) _____

Is there anything you can do to relieve the problem? Yes No If yes describe: _____

It Interferes with: Work Sleep Walking Sitting Hobbies Leisure

Please check your current pain level below:

- 0 1 2 3 4 5 6 7 8 9 10
Normal Mild Moderate Severe Excruciating

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Neck Pain/ Stiffness | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Severe Nervousness | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Pain |
| <input type="checkbox"/> Numbness in upper limb | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Numbness in lower limb | <input type="checkbox"/> Constipation | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Fever in the past month |
| <input type="checkbox"/> Hypersensitive Eyes | <input type="checkbox"/> Diarrhea in past year | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hot Flashes in past year |
| <input type="checkbox"/> Buzzing/ringing in Ears | <input type="checkbox"/> Significant Tension | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold Sweats in past year |
| | | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Sleeping Problems |

Please note any major illnesses you have had: Heart disease Cancer Diabetes Other: _____

Please list any major accidents or surgeries you have had: _____

Please list any medications you are taking: _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your family members below:

| Name | Relation | Condition(s) |
|------|----------|--------------|
| | | |
| | | |
| | | |

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

 Name Signature Date



ROBICHAUD
Family Chiropractic

Name: _____

Date: _____

Please review and then sign below acknowledging that you are aware of the fees.

Fee Schedule

Adult

| | |
|--------------------------|----------------|
| Initial Assessment | \$60.00 |
| Report of Findings | \$33.00 |
| Subsequent Visit | \$33.00 |
| Reassessment..... | \$55.00 |

Student/ Senior (65 and older) Child (under 16)

| | |
|--------------------------|----------------|
| Initial Assessment | \$60.00 |
| Report of Findings | \$33.00 |
| Subsequent Visit | \$25.00 |
| Reassessment..... | \$50.00 |

Custom Made Orthotics *

| | |
|--|-----------------|
| 1 Pair of Custom Fitted Orthotic Inserts | \$450.00 |
| 1 Pair of Custom Fitted Orthotic Shoes/Sandals ... | \$575.00 |

** Full payment is required on the day of the orthotic casting*

Spinal Nerve Scan

| | |
|-------------------------------|------------------|
| Any combination of tests..... | \$30.00** |
|-------------------------------|------------------|

*** Included with initial assessment and reassessment if required.*

Nutritional Supplements

Range from \$19.95 to \$58.00. We will gladly provide you with our supplement price list and/or prices on specific supplements upon request.

Prepayment Savings Options

1. Prepay **\$300.00** and **save 5%** on all chiropractic visits, nutritional supplements and products sold by Dr. Robichaud/Robichaud Family Chiropractic except custom made orthotics until the \$300.00 is spent.
2. Prepay **\$500.00** and **save 8%** on all chiropractic visits, nutritional supplements and products sold by Dr. Robichaud/Robichaud Family Chiropractic except custom made orthotics until the \$500.00 is spent.
3. Prepay **\$800.00** and **save 10%** on all chiropractic visits, nutritional supplements and products sold by Dr. Robichaud/Robichaud Family Chiropractic except custom made orthotics until the \$800.00 is spent.

Payment is due when the service is rendered. Receipts are provided upon your request. Please note that many private insurance companies pay towards chiropractic care and custom made orthotics. Please consult your insurance plan for more details. If you have been injured at work or involved in a recent automobile collision please let us know so we can make arrangements to bill on your behalf.

I have read and understand the fee schedule.

Signature of Patient/Legal Guardian: _____



NOTE TO PATIENT: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

I, _____
Print/Type Name

have read the below statement and consent to treatment:

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or strokes like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in five million. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions.

I understand all accounts are payable when service is rendered.

I understand that to provide me with health goods and services, Dr. Adrian Robichaud will collect some personal information about me (e.g., home telephone number, address).

I understand that Dr. Adrian Robichaud has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.

I understand that I may receive the following: newsletters, Thank you cards, Birthday cards, phone calls, health packages etc. that may be of interest to me.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Dr. Adrian Robichaud collecting, using, and disclosing personal information about me as set above and in Dr. Adrian Robichaud's Privacy Policy.

I am aware that Dr. Robichaud may from time to time use technology that is considered experimental by the College of Chiropractors of Ontario and grant my consent for Dr. Robichaud to use this technology to help my condition.

I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions.

Signature of Patient (or legal guardian): _____

Signature of Witness: _____

Witness Name: _____

Please print name above

Date: _____