MURRAY **CHIROPRACTIC** GROUP

CONFIDENTIAL CASE HISTORY

Date:_____

PERSONAL INFORMATION:

Last Name _____ First Name _____
Do you prefer: ☐ First name ☐ Mr ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr ☐ Other _____
Address _____ City _____ Prov._____ Postal _____
Birth date; M:____ D:____Y:_____ Age____ Marital Status; ☐M ☐S ☐W ☐D
Home Tel. _____ Cell Phone_____ Work Tel. _____
Occupation _____ Employer _____
Spouse's Name _____ Children's Name _____
What occupies your spare time? _____
Who referred you to our office?_____
Name of regular Medical Doctor _____
Email Address _____

HEALTH INFORMATION:

Have you had previous chiropractic care? ☐ yes ☐ no When? _____ Why? _____
Have you ever had x-rays? ☐ yes ☐ no For what reason? _____
What is your major complaint? _____
How long have you had this condition? _____Have you had it before? ☐ yes ☐ no
What aggravates your condition _____
Is it getting: ☐ Better ☐ Worse ☐ Constant ☐ Comes and goes
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____
How long has it been since you really felt good ? _____
Others who treated this condition: _____
List surgical conditions and years: _____
Drugs you now take: ☐ Pain killers ☐ Muscle relaxants ☐ Birth control ☐ Vitamins ☐ Other _____
_____
Are you wearing: ☐ Heel lifts ☐ Orthotics ☐ Special supports or braces _____
Have you ever been in an automobile accident? ☐ Never ☐ Past year ☐ Within 5 years ☐ More than 5 years ago Describe: _____
Have you ever had any other personal injury or accident? ☐ yes ☐ no Describe: _____

REASON FOR CONSULTING THE OFFICE:

☐ I have a specific problem and only require help with this problem.
☐ After my problem has been relieved, I am interested in strategies to ensure the problem does not return.
☐ Spinal checkup and to improve my general health.

105-4400 Chatterton Way Victoria BC V8X 5J2 Tel: (250) 881-7881 Fax: (250) 881-7882

HEALTH HISTORY:

To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem. Pain is often referred from other areas or it may be related to a more serious underlying pathology.

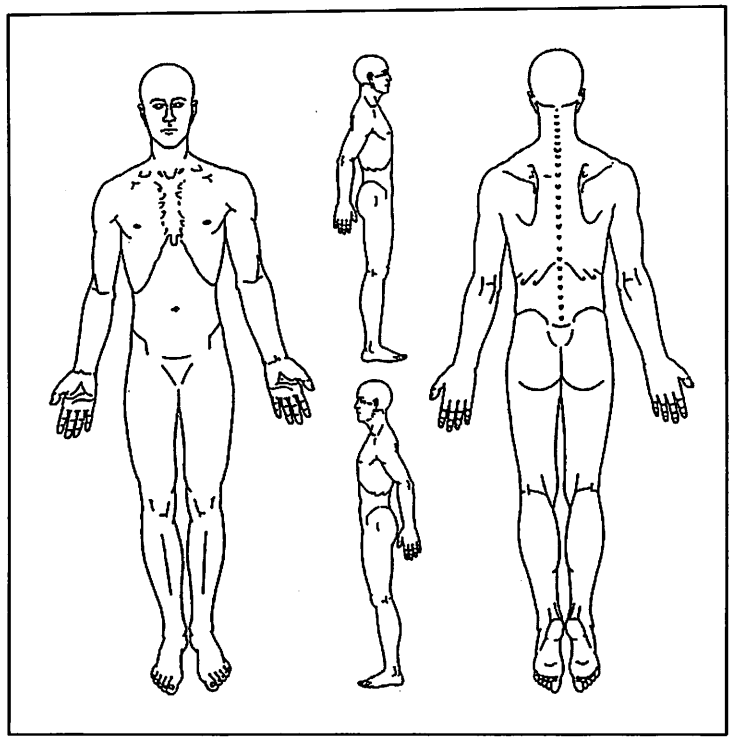
Have you ever suffered from:

1. Dizziness	☐ Yes	☐ No
2. Heart trouble	☐ Yes	☐ No
3. Diabetes	☐ Yes	☐ No
4. Arthritis	☐ Yes	☐ No
5. Asthma	☐ Yes	☐ No
6. Cancer	☐Yes	☐ No
7. Digestive problems	☐Yes	☐ No
8. Numbness	☐ Yes	☐ No
9. Tingling	☐ Yes	☐ No
10. Bladder trouble	☐ Yes	☐ No
11. Kidney trouble	☐ Yes	☐ No
12. Backaches	☐ Yes	☐ No
13. Neck pain	☐ Yes	☐ No
14. Headaches	☐ Yes	☐ No

FEMALES:

1. Severe menstrual pain	☐ Yes	☐ No
2. Vaginal pain	☐ Yes	☐ No
3. Breast pain	☐ Yes	☐ No
4. Lumps on breast	☐ Yes	☐ No

Please mark the main areas of pain on the figures below:



Make a mark (/) along the line which you think represents your current level of pain in your major area of injury, somewhere between "No Pain at all" and "Severe Pain"

No Pain at all — Severe Pain

FAMILY HEALTH INFORMATION (Past or present health problems):

Mother: _____

Father: _____

Siblings: _____

Type of Coverage: ☐ MSP ☐ WCB ☐ ICBC ☐ Other: _____

Medical Number: _____

MURRAY CHIROPRACTIC GROUP

OFFICE POLICY

REGULAR PATIENTS

- The office fee is $70.00 for an initial visit and $50.00 per subsequent visit.
- If your MSP premiums are currently subsidized by MSP your first treatment will be $35.00 with subsequent visits at $30.00 (within the 10 visit yearly limit), then it will be $35.00.
- The office fee for missed appointments, or cancellation without 24 hours notice is $10.00.
- Patients who have been absent from care for more than six months will be subject to a $5.00 re-examination fee.
- Patients are required to inform staff of new injuries or complaints. A one-time examination fee of $5.00 will apply in addition to the regular office fee.

Payment must be made on the date of service. This office does not bill. If you do not bring the fee at the time of service, you will be asked to bring it in later that same day. This will assist in our cash balancing. Failure to do this will incur a $5.00 handling fee.

WORKERS' COMPENSATION BOARD

Please report immediately to the staff if your visit is to be billed to WCB, so the correct forms get submitted and M.S.P. is not incorrectly billed. **Patients are responsible for the office fee until which time WCB has fully accepted the claim. We will keep your credit card number on file or a post dated cheque in the amount of $450.00.**

ICBC PATIENTS

As there are many forms to fill out for ICBC and they too are billed separately from MSP please let the receptionist know ahead of time that you should be billed under ICBC.

SIGNATURE _____ DATE _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

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