WELCOME to ROYAL YORK CHIROPRACTIC !

To ensure your visit with us is a pleasant one, here are the procedures you can expect during your visit.

PAPERWORK: Kindly complete this questionnaire. The doctor will use this to formulate his recommendations for your care.

CONSULTATION: You will meet the Doctor and his technical assistant(s). The Doctor will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.

EXAMINATION: Standard physical, orthopaedic, neurological and chiropractic testing, including computerized scanning, will be performed to determine the cause(s) of your health problems and subluxations.

SPINAL IMAGES: Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathologies and make your chiropractic care more precise.

KIDS' CONFIDENTIAL PATIENT CASE HISTORY to be COMPLETED by PARENT or GUARDIAN

Name: _____ Home Phone: _____

Address: _____

City: _____ Postal Code: _____ Mobile / Pager: _____

Parents' Email Address: _____

Child's Email Address: _____

In order to conserve paper, we prefer to communicate office information and newsletters primarily by email. We will not share your email address with any third party. By providing your email address, you consent to receiving periodic office information via email.

☐ ✔ Check here to get FREE text message reminders for your child's future appointments

Age: _____ Date of Birth: _____ Height: _____ Weight: _____
day month year

Name and Telephone of Medical Doctor: _____

Has YOUR CHILD had CHIROPRACTIC care? _____ Has YOUR CHILD worn FOOT ORTHOTICS? _____
when? when?

Name of previous CHIROPRACTOR: _____

Whom may we thank for referring your CHILD ? _____

Do you have extended health insurance? yes ☐ no ☐ Annual value of health insurance for chiropractic: $ _____

Annual value of health insurance for foot orthotics: $ _____

Reason for today's visit : _____

Thanks! Please turn over the page.

SOURCES of SPINAL STRESS that CAUSE SUBLUXATIONS

To help us determine the <u>exact cause</u> of your problem, please indicate on this page any potential sources of spinal trauma.

1. BIRTH TRAUMA - with respect to **<u>your CHILD'S</u>** birth process, please check all that apply:

- ☐ Natural
- ☐ Premature
- ☐ Breech
- ☐ Forceps
- ☐ Vacuum Extraction
- ☐ Epidural / Drug Induced
- ☐ C-Section
- ☐ Cord around Neck
- ☐ Prolonged Delivery
- ☐ Pulling / Twisting by the Delivery Doctor
- ☐ Not Sure

Did **<u>the child's mother</u>** sustain any falls, accidents or injuries during pregnancy?

- ☐ Yes
- ☐ No
- ☐ Not Sure

2. CHILDHOOD ACCIDENTS / INJURIES - please **check** all that apply:

- ☐ Fell down _____ Injuries: _____
- ☐ Car Accident _____ (date(s)) Injuries: _____
- ☐ Car Accident _____ (date(s)) Injuries: _____
- ☐ Other _____ (date(s)) Injuries: _____
- ☐ Sports Injury _____ (date(s)) Injuries: _____
- ☐ Physical Fight _____ (date(s)) Injuries: _____
- ☐ Other _____ (date(s)) Injuries: _____

3. GESTATIONAL, NEONATAL and CHILDHOOD and HEALTH - please **check** all that apply:

Did mother have complications during **pregnancy ?** yes ☐ no ☐ Please list: _____

Did mother have complications during **delivery ?** yes ☐ no ☐ Please list: _____

Did mother have ultrasounds during pregnancy ? yes ☐ no ☐ Number: _____

Did mother have chiropractic care during pregnancy ? yes ☐ no ☐

Medications during pregnancy / delivery ? yes ☐ no ☐ Please list: _____

Smoking / Alcohol during pregnancy ? yes ☐ no ☐

Breast Fed: yes ☐ no ☐ duration: _____ Formula Fed: yes ☐ no ☐

Introduced to cow's milk at: _____ Introduced to solids at: _____

Any food allergies / sensitivities: _____

Has your child been vaccinated ? yes ☐ no ☐ Has your child had any reaction to vaccination ? yes ☐ no ☐

How many vaccines ? _____ Please list reactions: _____

Thanks! Please go to the next page.

4. HOSPITALIZATIONS, OPERATIONS and ILLNESSES - please list all details and approximate dates:

_____

_____

_____

5. Please list any medication (prescription or over-the-counter) CHILD has taken in the past 6 months and list how often:

_____

_____

_____

6. AUTOMOBILE ACCIDENTS - **has your CHILD, even as a passenger**, been involved in a car accident or near collision? (even if you think you they not hurt) ☐ Yes ☐ No

If you answered **YES to question 6**, please complete the following:

Accident Date: _____

Description of Accident: _____

_____

_____

Speed of Collision _____

Severity of Damage: _____

Injury after Accident: _____

Who Examined You: _____

X-Rays Taken: _____

Did you see a Chiropractor? ☐ Yes ☐ No

Accident Date: _____

Description of Accident: _____

_____

_____

Speed of Collision _____

Severity of Damage: _____

Injury after Accident: _____

Who Examined You: _____

X-Rays Taken: _____

Did you see a Chiropractor?

7. Primary Daily Activities - constant poor posture will lead to spinal stress and subluxations.

☐ Sitting _____ hours per day

☐ Standing _____ hours per day

☐ Walking _____ hours per day

☐ Computer _____ hours per day

☐ Video Games_____ hours per day

☐ Other _____

Thanks! Please turn over the page.

8. Where is the location of your CHILD'S major complaint?

☐ Right ☐ Left ☐ Center ☐ Both Sides ☐ Upper ☐ Lower

9. How does this affect their life in general? (example: physical activity, mood, work productivity, family life, etc.)

_____

10. Spinal stress can generate **different types of discomfort throughout the body.** Describe what **your CHILD** feels:

☐ Burning	☐ Diffuse	☐ Dull / Aching	☐ Sore
☐ Stabbing	☐ Tingling	☐ Radiating	☐ Throbbing
☐ Sharp	☐ Shooting	☐ Localized	☐ Other _____

11. Spinal stress can also **choke the nerves, causing pain to travel to different parts of the body.** For example, neck pain can travel down the arms and back pain down the legs. **Has YOUR CHILD experienced any traveling pain?**

☐ Yes ☐ No If **yes, pain travels from** _____ **to** _____
(please indicate side of body)

12. Spinal stress can put pressure **on the spinal cord and nerves,** causing symptoms to come and go over time. Is **YOUR CHILD'S** condition **CONSTANT** or **INTERMITTENT?** (circle one)

13. Circle on a scale of 1-10 how you **YOUR CHILD** would rate THEIR **discomfort:**

no pain moderate pain extreme pain

1 2 3 4 5 6 7 8 9 10

14. What have you found that **AGGRAVATES** THEIR symptoms?

_____

15. What have you found that **IMPROVES** THEIR symptoms?

_____

16. Who has your CHILD **already consulted** in an attempt to correct this problem? (eg. Chiropractor, massage therapist, physio)

_____

Thanks! Please go to the next page.

About Your Health ...

The human body is designed to be healthy. Throughout life, events occur which damage your expression of health . This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your report of findings your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate or inborn health potential.

PRESENT HEALTH: Is your child CURRENTLY affected by any of the following ? (please CIRCLE)

MUSCLE and JOINT	GENERAL SYMPTOMS	GASTROINTESTINAL	CARDIOVASCULAR	STRESS SYMPTOMS
Backache	Fever / Chills / Sweats	Difficult digestion	Rapid heart beat	Headache / Migraine
Neck pain	Fainting	Belching or gas	Slow heart beat	Dizziness
Foot trouble	Convulsions	Nausea or vomiting	High blood pressure	Numbness / pins & needles
Shoulder pain	Allergy	Stomach pain / heartburn	Low blood pressure	Ringing in ears
Hernia	Skin problems	Constipation	Chest pain	Loss of sleep
Spinal curvature	Colds	Colon trouble	Swelling of ankles	Poor concentration
Poor posture	Tremors	Liver trouble	Poor circulation	Irritable / Nervousness
Arthritis	Loss of balance	Gall Bladder trouble		Depression
		Diarrhea		Decreased energy / fatigue
		Bloody stools		Tension

RESPIRATORY	URINARY	E.E.N.T.	FEMALE ISSUES	
Chronic cough	Painful urination	Deafness	Painful menstruation	Abnormal discharge
Spitting up phlegm / blood	Waking up at night - urinate	Earache	Excessive flow	Birth Control Pill
Chest pain	Blood in urine	Sore throat	Irregular menstruation	
Difficulty breathing	Increased urination	Asthma	Cramps or backache	
		Tonsillitis		
		Sinus trouble	Date of last menstrual period: _____	

PAST HEALTH: Has your child ever suffered from any of the following IN THE PAST ? (please CIRCLE)

Thyroid trouble	Emotional problems	Asthma
Diabetes	Epileptic seizures	Tuberculosis
Pneumonia	Psoriasis	
Stomach ulcers	Polio	Other: _____
Previous stroke	Cancer	_____

INFORMED CONSENT TO CHIROPRACTIC CARE and OFFICE POLICIES

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on me by Dr. Peter Hryciuk or anyone working in this clinic authorized by him. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures. I understand as in all health care that results are not guaranteed. I further understand and am informed that in the practice of chiropractic, as in all health care, there are some extremely rare risks to treatment, including, but not limited to; muscle strains, sprains, disc injury and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on his ability to exercise judgement during the course of the procedure which he feels at the time, based on the facts known, is in my best interest.

All outstanding balances are to be settled at the end of each week. In the event you would like to sign out any x-rays the fee is $40. Chiropractic key fobs and cards are the property of RYCC and the replacement cost is $10. Missed appointments (no shows) without 24 hours notice are subject to a charge. Please be advised that an absence of 90 days without chiropractic care will require a re-examination at a fee of $50.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above mentioned chiropractic procedures. I intend this consent form to cover the entire course of treatment for any of the conditions which I may have.

TO BE COMPLETED BY PARENT or LEGAL GUARDIAN:

_____	_____	_____
PATIENT NAME	SIGNATURE (Patient or Guardian)	DATE

Royal York Chiropractic
Payment Office Policy Sheet

Please be advised that our office policy regarding payments for chiropractic care and related products is as follows:

1. The monthly payment option requires that you make a regular payment for chiropractic care on the 1st or the 15th of the month. Also note that the monthly payment option is by way of autobilling your credit card which you must leave on file at the office or provide us with post dated cheques which also remain on file at the office. In the event that you do not attend your chiropractic care for a specified month, as you are on a regular payment plan, you are still required to make the regular payment **without exception**.

2. Patients that wish to make a one time payment for chiropractic care (one time option) may pay by VISA, Mastercard, AMEX, Debit Card, Cheque or Cash.

3. Patients that wish to pay per visit for chiropractic care are **required to pay when the service is rendered or they may clear their account at the end of the week.** Overdue accounts will be subject to a concurrent 2.5% monthly service charge.

4. In event that you drop out of care prematurely, the full amount outstanding on your account will become due. This will immediately be billed to the credit card we have on file. A service charge of 2.5% of the original credit card charge will appear on your account. In the event that you have a credit on file, please notify us and we will gladly refund it by way of cheque.

5. Motor Vehicle Accident and WSIB patients are reminded that, in the event their insurance company does not pay for their chiropractic care, they are responsible for the entire balance outstanding.

6. Missed appointments (no-shows) are billed for the full service unless they are made up during the same week. Adjustments are $40.00 and examinations are $50.00. If you are on a plan, this amount will be deducted from your plan, thus affecting your year end date. If you would like to sign out and keep your x-rays for any reason, there is a $40.00 charge. Replacement charge for lost key-fobs and cards is $10.00. An absence of 90 days without chiropractic care will require a re-examination at a fee of $50.

7. We will provide monthly receipts reflecting services rendered to you to file with your insurance company for reimbursement. We will also provide receipts for income tax purposes on an annual basis when requested.

I hereby fully agree to and will abide by the Royal York Chiropractic Payment Office Policy.

Name in Full _____

Signature _____ Date _____

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