Royal York Chiropractic

Dr. Peter J. Hryciuk, B.Sc. D.C. and Dr. Marco Capizzano, B.Sc. D.C.
4237 Dundas St. W. Toronto Ontario M8X 1Y3 416.233.5413

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 will be performed to determine the cause(s) of your health problems.

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: _____ SEX: male ☐ female ☐

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? _____ when? Has YOUR CHILD worn FOOT ORTHOTICS? _____ 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.

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Patient Name: _____

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

1. BIRTH TRAUMA - with respect to **your CHILD'S** 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 **the child's mother** 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.

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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.

☐ Sitting _____ hours per day

☐ Standing _____ hours per day

☐ Walking _____ hours per day

☐ Computer _____ hours per day

☐ Video Games_____ hours per day

☐ Other _____

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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, physiotherapist)

_____

Thanks! Please go to the next page.

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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 may 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: Are you CURRENTLY affected by any of the following ? (please CIRCLE)

MUSCLE and JOINT

Backache
Neck pain
Foot trouble
Shoulder pain
Hernia
Spinal curvature
Poor posture
Arthritis

STRESS SYMPTOMS

Headache / Migraine
Dizziness
Numbness / pins & needles
Ringing in ears
Loss of sleep
Poor concentration
Irritable / Nervousness
Depression
Decreased energy / fatigue
Tension

URINARY

Painful urination
Waking up at night - urinate
Blood in urine
Increased urination

GENERAL SYMPTOMS

Fever / Chills / Sweats
Fainting
Convulsions
Allergy
Skin problems
Colds
Tremors
Loss of balance

RESPIRATORY

Chronic cough
Spitting up phlegm / blood
Chest pain
Difficulty breathing

FEMALE ISSUES

Painful menstruation
Excessive flow
Irregular menstruation
Cramps or backache
Abnormal discharge
Post menopause
Birth Control Pill
Miscarriages

Date of last menstrual period:

_____

GASTROINTESTINAL

Difficult digestion
Belching or gas
Nausea or vomiting
Stomach pain / heartburn
Constipation
Colon trouble
Liver trouble
Gall Bladder trouble
Diarrhea
Bloody stools

CARDIOVASCULAR

Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Chest pain
Swelling of ankles
Poor circulation

E.E.N.T.

Deafness
Earache
Asthma
Tonsillitis
Sinus trouble

PAST HEALTH: Have you ever suffered from any of the following IN THE PAST ? (please CIRCLE)

Thyroid trouble
Diabetes
Tuberculosis
Pneumonia
Stomach ulcers
Previous heart attack
Emotional problems
Epileptic seizures
Asthma
Alcoholism
Psoriasis
Previous stroke
Polio
Cancer
Venereal Disease
AIDS / HIV

Other: _____

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Payment Office Policy Sheet

Please be advised of our office policy regarding payments for chiropractic care and related products:

1. 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.

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

3. 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, and you have an outstanding balance, you are still required to make the regular payment **without exception**.

4. In the 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. If you paid using credit card or debit card, a service charge of 2.5% of the original charge will appear on your account, together with missed appointment charges. In the event that you have a credit on file, please notify us and we will gladly refund it by way of cheque.

5. As of December 1st, 2014, and according to the Superintendent's Guideline no. 04/14, all motor vehicle accident patients who wish to file claims must prepay for their chiropractic care in advance. Patients will be reimbursed via their extended health insurance and/or motor vehicle company insurance(s).

The guidelines are as follows:

- Completion of all OCF documents according to claims.
- Payment in full according to financials allotted.
- After an adjustment is rendered, patient must sign off on all chiropractic statements.
- Royal York Chiropractic will fax invoices directly to insurer.
- Patient must mail chiropractic invoices directly to insurer.

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 is $10.00. Fees for copying full patient file are a $100 minimum charge.

7. We will provide monthly receipts reflecting services rendered for 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 _____