

Advanced Therapeutics

1398 Queen St. E.
Toronto, Ont. M4L 1C9
416-469-3879

Patient Information

Name_____ Date_____

Date of Birth_____ Employer_____

Address_____ Work phone#_____

City_____ Work duties_____

Postal Code_____ _____

E-mail_____ Emergency contact_____

Home phone#_____ Phone_____

Cell phone#_____ Referred to our office by_____

Please list other Health care providers:

| Type of Health care | Name | Phone # |
|---------------------|------|---------|
| | | |
| | | |
| | | |

YES/NO Can we send you information regarding upcoming office events via email?

Purpose of this appointment:

MEDICAL HISTORY

List any accidents/falls you have had through childhood (include work/auto).

- 1. _____
- 2. _____
- 3. _____
- 4. _____

List any major medical surgeries you have had.

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Have you had any fractures? _____ If so, where _____

List any previous medical diagnosis and treatment you have had for this condition.

What do you think has caused or aggravates this condition?

What is your general state of health? (Circle one) Excellent Good Fair Poor

When was the last time you really felt good? Weeks___ Months___ Years___

Date of last Chiropractic treatment _____

Type of treatment _____

Time under care _____

Date of last physical exam? _____ What prompted exam? _____

Date of last lab work? _____ Date of last x-ray? _____ Body part? _____

Name: _____ Date: _____

Do you currently take any of the following? (Indicate how many and how long)

1. Vitamins/herbs/supplements _____
2. Birth Control _____
3. Over the counter drug _____
4. Pain med/muscle relaxant _____
5. Blood pressure medicine _____
6. Insulin _____
7. Laxative _____
8. Recreational drug _____
9. Prescribed medication _____
10. Other _____

To help us understand your total health, please provide information about your family members. Many conditions are the result of hereditary weakness.

Have you or your siblings, parents, or grandparents had any of the following?

- Heart disease/Attack/circulatory problems _____
- Kidney disease _____ Thyroid disease _____
- Cancer _____ Autoimmune disease _____
- Rheumatoid Arthritis _____ other arthritis _____
- Cerebral vascular disease/stroke/TIA _____
- Respiratory disease/Asthma/Emphysema/Chronic Bronchitis _____
- Allergies _____ Scoliosis _____
- Gastrointestinal disease, Crohns, ulcers, IBS _____
- Diabetes _____ High Blood Pressure _____
- Mental illness or social dysfunctions, ADD, ADHD, seizure or convulsions _____
- _____

Name: _____ Date: _____

Do you use any of the following? Check if yes

Antihistamines_____

Alcohol_____

Tobacco_____

Coffee_____

Tea_____

If answered Yes to any of the previous explain here:

| Type of Physical Activity | Frequency | Duration | Intensity |
|---------------------------|-----------|----------|-----------|
| | | | |
| | | | |
| | | | |

What is your greatest health concern?

Are there secondary concerns you have?

List four health goals.

1. _____
2. _____
3. _____
4. _____

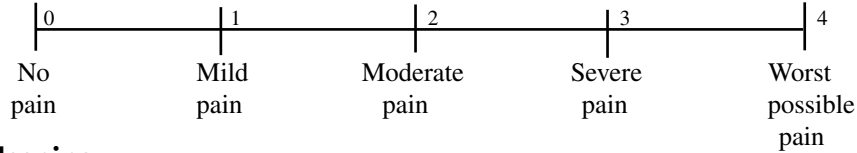
Name: _____ Date: _____

Functional Rating Index

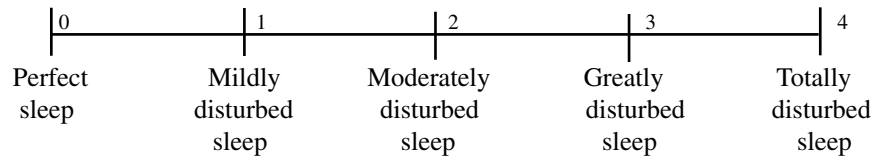
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

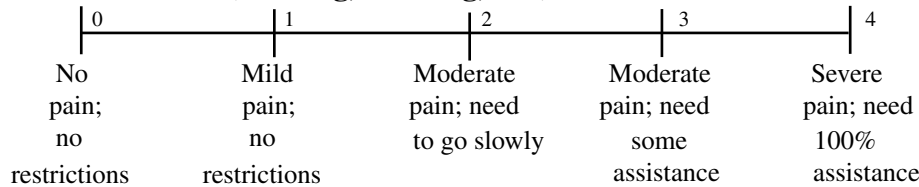
1. Pain Intensity



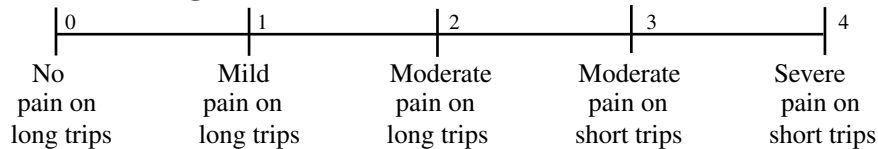
2. Sleeping



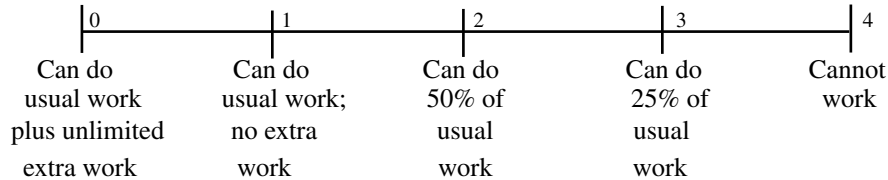
3. Personal Care (washing, dressing, etc.)



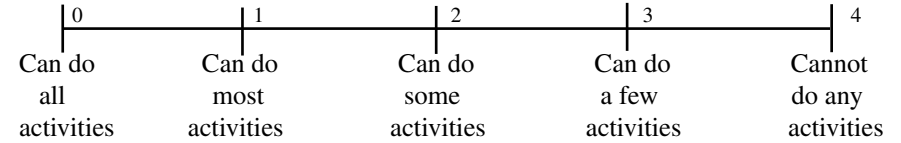
4. Travel (driving, etc.)



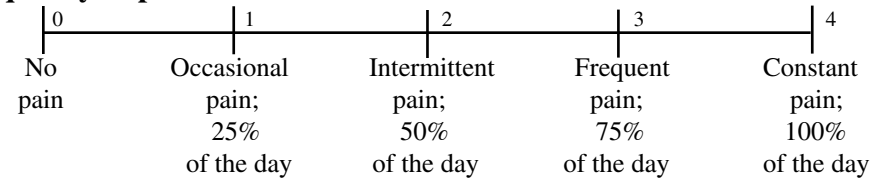
5. Work



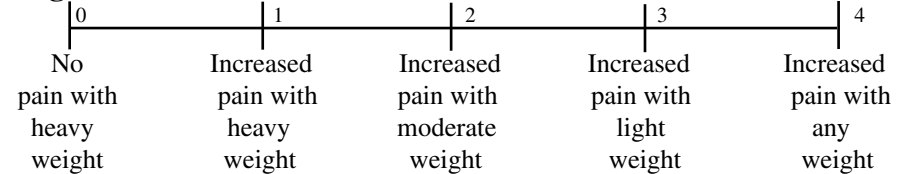
6. Recreation



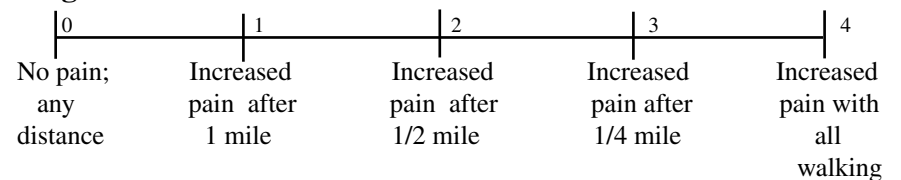
7. Frequency of pain



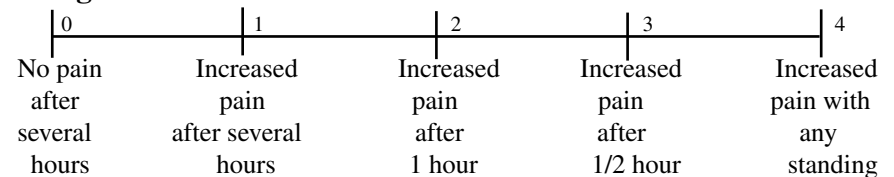
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Total Score _____

Dr. Nam Nguyen D.C
1398 Queen St. E
Toronto, Ont. M4L 1C9

Signature

Date

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.
- **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)

Signature of patient (or legal guardian)

Date: _____ 20____

Signature of Chiropractor

Date: _____ 20____

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Chiropractic fees

| Treatment | Cost |
|------------------------------------------------------------------|--------|
| New patient assessment/Doctor's report/Initial treatment | \$ 140 |
| Follow-up treatment | \$75 |
| Extended treatment &/or 6 month reactivation | \$100 |
| Student new patient assessment/Doctor's report/Initial treatment | \$110 |
| Student follow-up treatment | \$55 |

*Fees are HST exempt.

Insurance and Benefits Release:

I hereby authorize **Dr. Nguyen** to furnish my insurance carrier, benefits agent, attorney and any physician, any and all information regarding my health and treatment during any course of care. This includes copies of medical examination findings, x-ray reports, progress notes and my financial account.

As a CASH (Cash or Credit) patient I agree to pay at the time of service.

A copy of this authorization has the same validity as the original.

Patient Signature_____

Date_____

Effective March 17, 2021. Prices are subject to change without notice